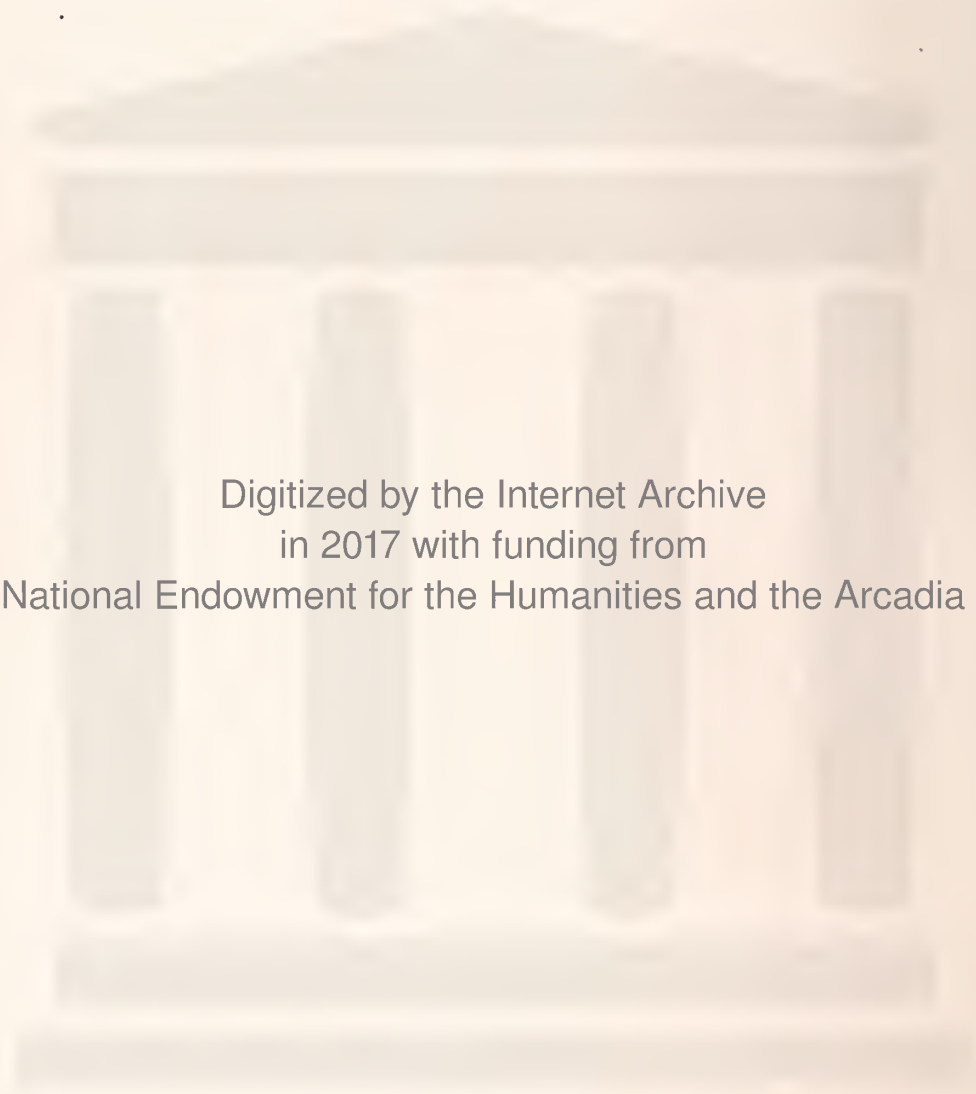
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## INTER-ISLAND NURSES' BULLETIN

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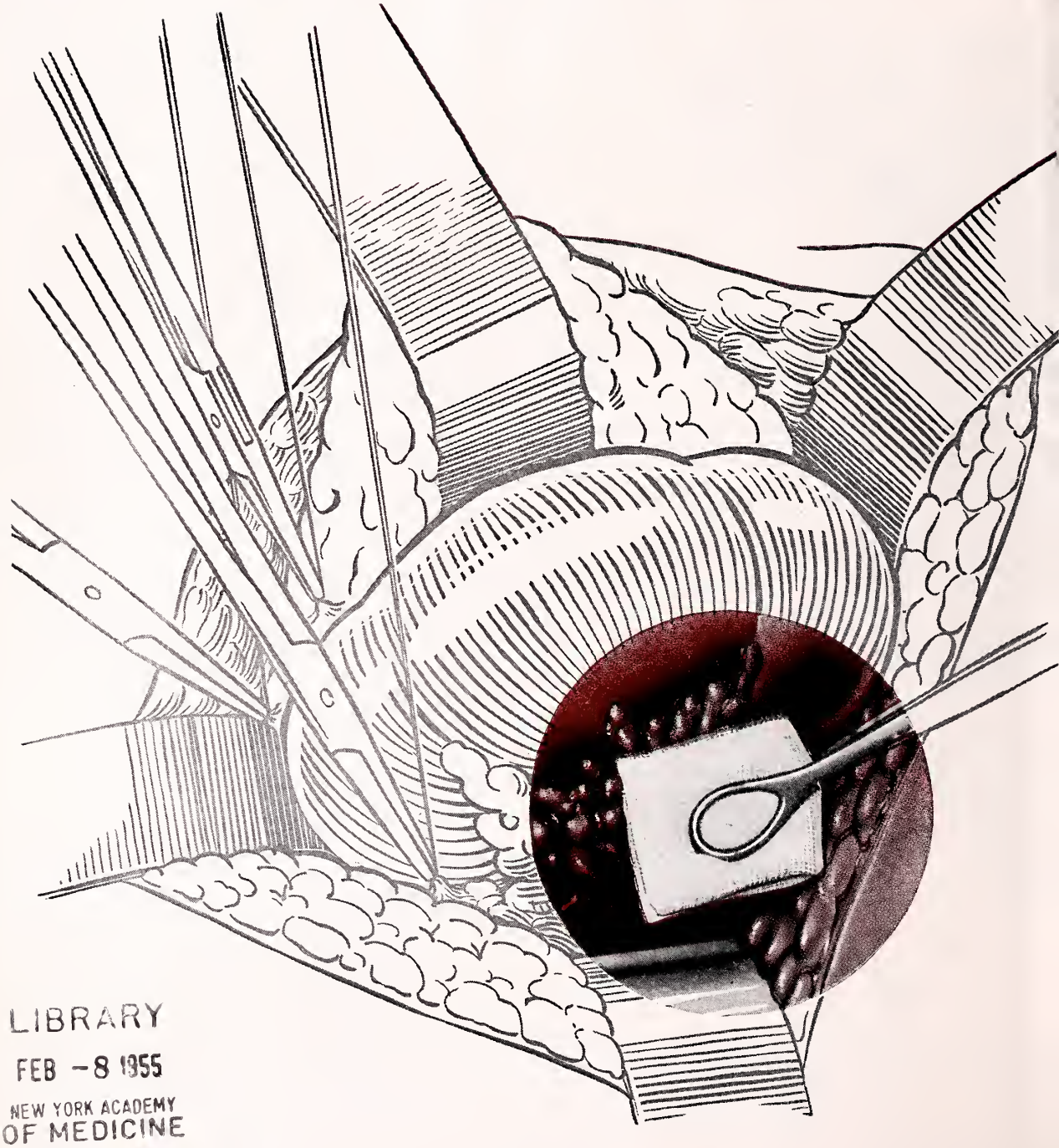


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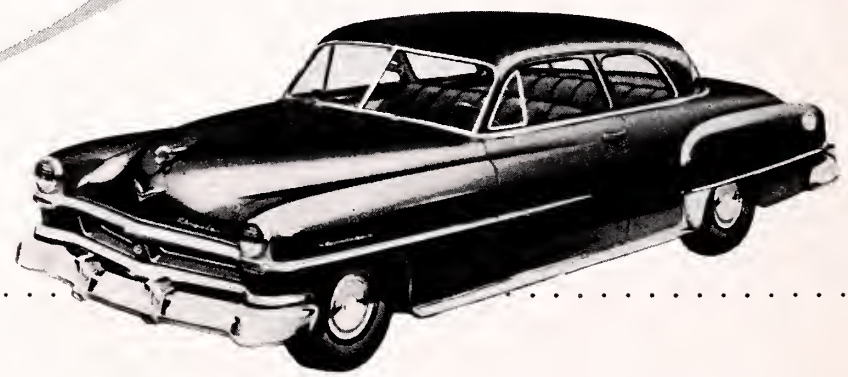
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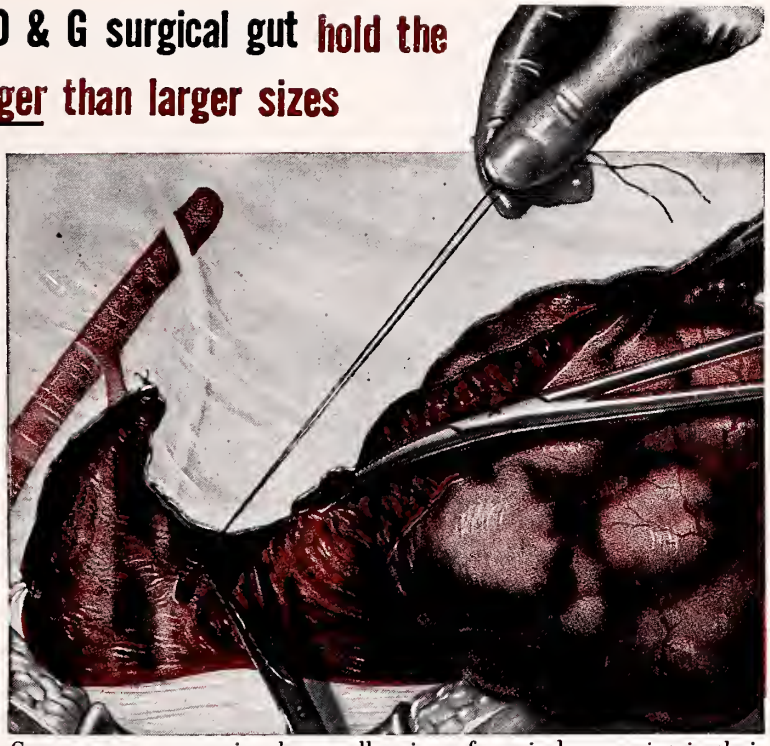
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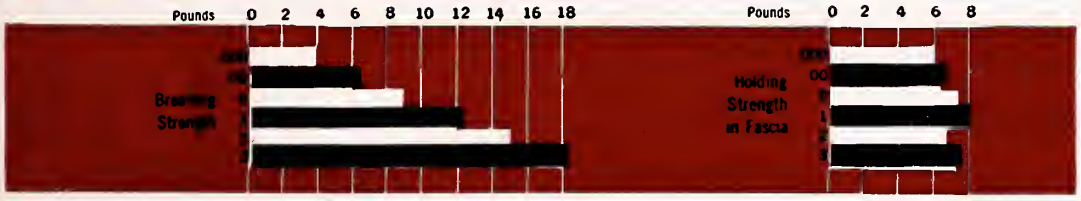
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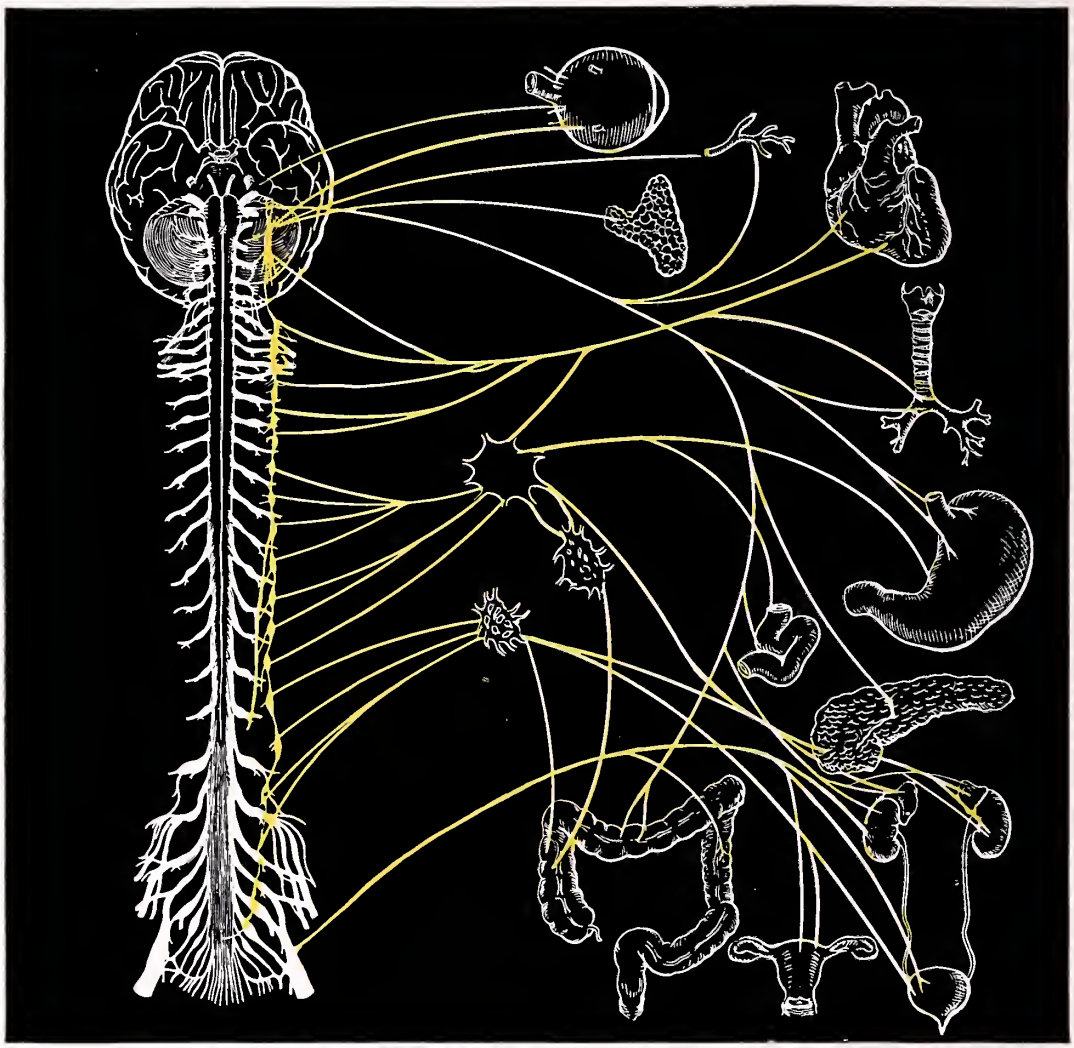
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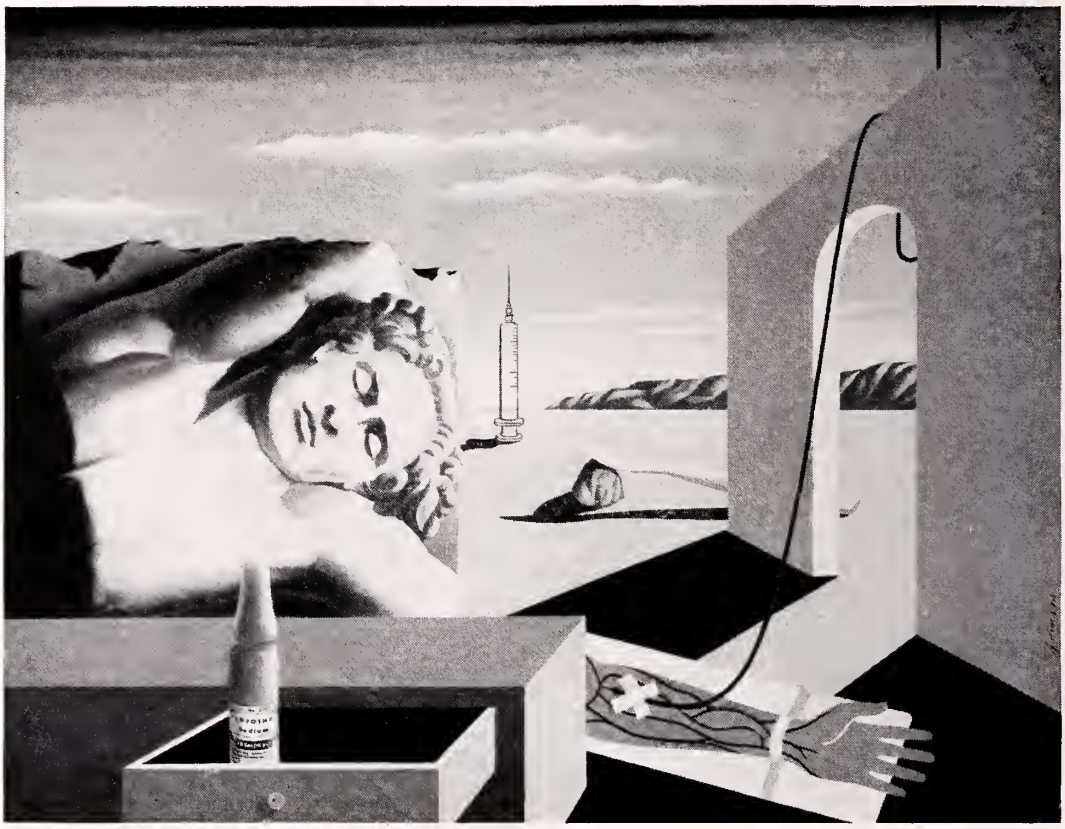
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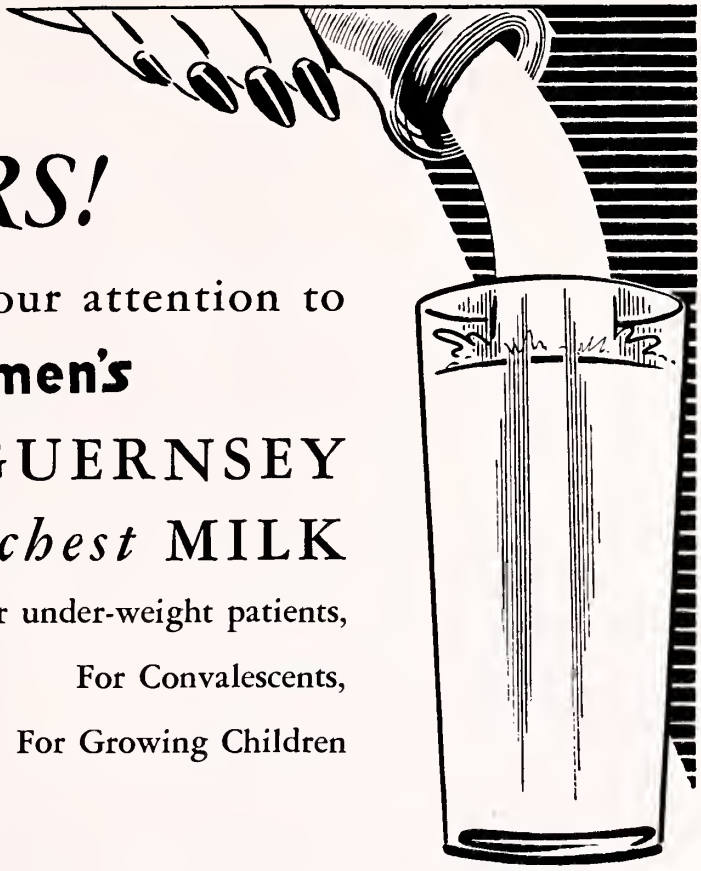


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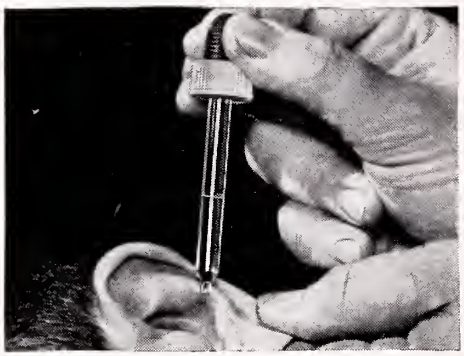
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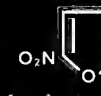
*Anderson, J. R. and Steele, C. H.: Laryngoscope 58:1279 1948. Douglass, C. C.: Laryngoscope 58:1274 1948. Long, P. H.: A-B-C's of Sulfonamide and Antibiotic Therapy, Philadelphia, W. B. Saunders, 1948, p. 152.

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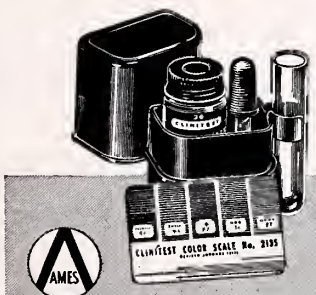
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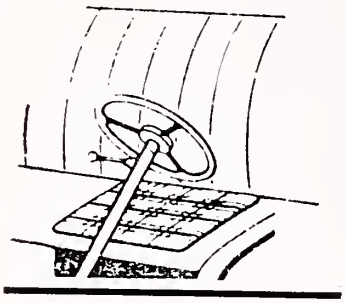
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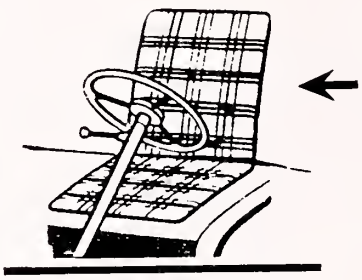



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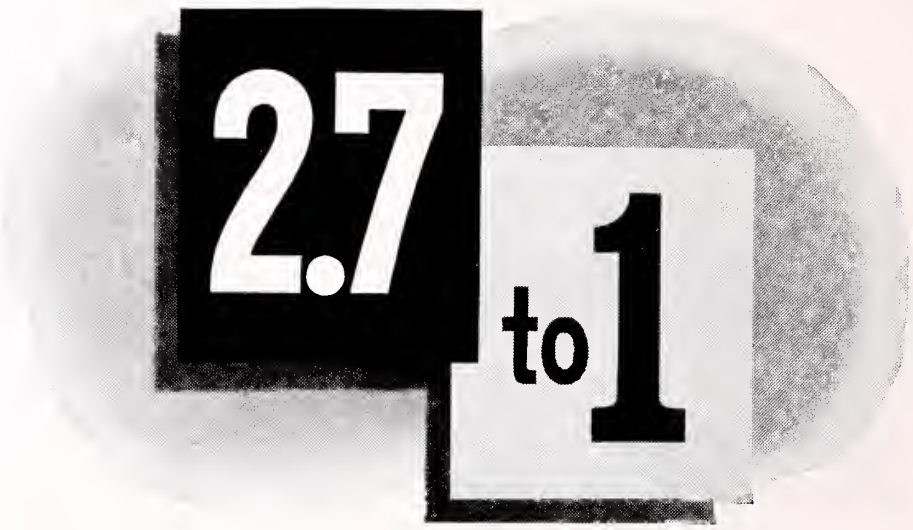
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# Doctor Harris attends a convention

More medical progress has occurred in his lifetime than in a dozen previous generations. Two-thirds of the medicines he uses today were unknown only ten years ago. As a result of this progress, he has acquired the problem of keeping abreast. He solves it in some measure by attending medical conventions, where he listens to lectures on most recent developments. There, too, he visits technical exhibits and learns of the most recent products from companies whose support helps make these conventions possible.

At one of these, back in the twenties, Dr. Harris was astonished by the announcement that an ancient Oriental herb had received scientific support. This was the beginning of a whole new series of ever-improving medicines. Oddly enough . . .





## . . . it all began with Ma Huang

In the Chinese village of his birth, young Chen had seen things which assured him that many of the herbs which his people had used for thousands of years were potent remedies. This he believed despite his respect for the Western doctor who would use only drugs from abroad—drugs which were scientifically established. Eventually his ambition to prove his belief brought him to America, where he studied pharmacy and, later, advanced chemistry, physiology, pharmacology, and, finally, medicine. Thus equipped, he returned to China, where he began his experiments with the herb Ma Huang. After isolating the active principle as crystalline ephedrine, he and Dr. Carl F. Schmidt conducted experiments and proved that ephedrine truly had the properties for which the crude drug had been used empirically. Following the well-received presentation of these facts to the 1926 convention of the American Medical Association, Dr. Chen accepted the direction of Lilly's pharmacologic research. There, continuation of his studies was instrumental in developing a series of even better synthetic decongestants. Thus, paradoxically, a small boy's faith in his people's traditions led to progress in modern medicine.

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# Evaluation of Modern Treatment for Pulmonary Tuberculosis

HOWARD BOSWORTH, M.D.*
LOS ANGELES, CALIFORNIA

FOR many years the treatment of pulmonary tuberculosis was limited to bed rest, tuberculin therapy, and so-called hygienic measures. Those who recovered were usually in early stages of the disease, as lungs with cavities seldom healed. Later, with pneumothorax, the prognosis for the more advanced cases improved. Surgeons then developed other types of collapse therapy, and more recently excisions of anything from a small wedge to an entire lung have become quite common and relatively safe. Now chemotherapy has stimulated more interest in research in the field of pulmonary tuberculosis than ever before. Every new treatment is greeted with enthusiasm, often before its effectiveness is proved. With the multiplicity of treatments now available, it is no wonder that we are all confused when we look for clearcut indications for any specific procedure while we continuously seek short cuts to recovery of health.



DR. BOSWORTH

The best way to evaluate the efficacy of any therapy is through long term follow-up, for which the opportunity does not yet exist with the most recent types. In order to evaluate treatment, there must be an understanding and agreement as to objectives. We are trying, whenever possible, to heal the disease, not just to arrest it. Second, we wish in so doing to interfere as little as possible with normal functions, particularly vital capacity and work tolerance; and third, we should make every effort possible to eliminate the tubercle bacilli from the patient's sputum at the earliest possible period. If we can do these three things, and restore the patient to a normal and productive life, we can consider our treatment a success. However, recognizing the fact that we cannot do this for all patients and that some will relapse, we evaluate results on degree of success achieved.

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Read before the Sixty-Second Annual Meeting of the Hawaii Territorial Medical Association, May 3, 1952.

### Type of Pathology Determines Treatment

We should keep in mind the underlying pathology when we choose treatment. We know that in some people the new tuberculous process will absorb and disappear completely. We also know that in others it may go on to caseation, ulceration and cavitation, and it may be either progressive at this point or it may become encapsulated and calcified. The progressive cases spread by contiguity, bronchogenic dissemination, hematogenous dissemination and dissemination through the lymphatics. Depending then upon the stage in which the pathology is discovered, the choice of treatment should be directed toward building up the required immunity, checking spread and destruction, and healing the existing foci.

### Four Main Types of Treatment

At present we can classify our treatments into four general types which we can use either separately or in combination with others. They are rest, collapse, excision, and chemotherapy.

Rest is fundamental for building immunity, whether used alone or with other measures.

Collapse is used to mechanically assist the healing of open lesions and to prevent dissemination of bacilli.

Resection serves to remove from the body overwhelming foci and those lesions and cavities which collapse therapy fails, or would fail, to control.

Chemotherapy to date has shown bacteriostatic effects but there is little evidence to prove any bactericidal benefits. However, by preventing multiplication and dissemination of bacilli, the use of these agents allows other treatments to be more effective and the progress of disease may be checked long enough for healing to take place.

The use and results of strict bed rest in the early treatment of disease are well established. It is basic therapy in the treatment of tuberculosis. The length of time it should be used varies with the individual patient. Realizing that the patient must heal himself, the first step in treatment is the building of immunity. Physical and mental rest, proper food, and hygiene all help, and oftentimes the primaries and the early minimals will clear on this treatment alone.

When caseation takes place, with ulceration and cavitation, the problem becomes more difficult. The cavity must be closed or blocked off, as it is a center for dissemination of disease throughout both lungs. If the cavity is recent and there is a reasonably good chance of its becoming encapsulated, some form of collapse therapy is usually indicated. If a bronchus leading to a cavity remains patent, the cavity may never close by itself. If, however, a bronchus becomes completely obstructed so that air cannot pass through it in either direction, atelectasis takes place, and the cavity shrinks until its inside surfaces are in apposition, after which encapsulation may occur. Collapse therapy usually promotes this type of healing.

Cavities filled with caseous material, in which progressive calcification often occurs, may also encapsulate, but these do not respond to collapse therapy. Neither do the so-called tension cavities, in which air is trapped through the valve-like action of an infected or stenotic bronchus. The older the lesion and the more scar tissue surrounding it, the less chance there is for collapse.

Resection now offers more hope for cases in which collapse therapy fails or for which collapse therapy is contra-indicated. Resection is also used to prevent reactivation of certain lesions which are temporarily controlled by streptomycin, a situation I will describe later.

As to the use of chemotherapy in treatment, there is no question but what recent discoveries have produced antibiotics and drugs that will be of great assistance to us in our management of cases. To date, none of these is a specific cure. Through their bacteriostatic action when combined with other treatments, they have been of value in increasing the effect of these other treatments. However, it might be better to plan therapy as though such drugs were not available, and then, having outlined the program for the patient, we can add these drugs as needed to supplement such treatment. If we depend solely on chemotherapy to cure tuberculosis, we may be making a mistake which will result in an injustice to the patient.

### Collapse Therapy

When we consider collapse therapy, the first thing we think of is artificial pneumothorax. For many years this was universally used for all types of advanced cases. Now, with many other treatments available, the indications of pneumothorax have narrowed considerably, and the use of pneumothorax has diminished to relatively small numbers. Recently there has been considerable controversy over the use of this form of collapse. Some surgeons advise abandoning it completely. In our own institution the long term results have been so satisfying that we cannot agree with this thinking. In well chosen cases in which a selective collapse of the cavity can be obtained, this is still one of the most satisfactory methods we have, as can be shown from long series of follow-up statistics over a period of years. There is no question, however, but that the most successful results of pneumothorax are found in those patients whose intelligence and economic status are high enough to assure cooperation and whose follow-up treatments can be given by well qualified physicians. The poor results usually occur in those who cannot fall into this group, so this factor must always be taken into consideration when treatment is planned. The disadvantages are the possible complications followed by poor re-expansion and the length of time of treatment required. In our own cases, if we believe adhesions are preventing the collapse of a cavity, and pneumonolysis appears feasible, we think it should be attempted as soon as possible; and if not feasible, or if unsuccessful, pneumothorax should be abandoned in favor of surgery. Pleural effusion, if persistent and endangering expansion of the base of the lung, may also be an indication for abandoning treatment; but we have found that, with judicious use of streptomycin along with pneumothorax, we have had fewer effusions and better results in general.

Extrapleural pneumothorax is another form of collapse now used less extensively. There are times when a cavity can be collapsed by this method without markedly decreasing pulmonary function, where a thoracoplasty to accomplish the same result would require removal of at least seven ribs. The disadvantage is that extrapleural pockets have a tendency either to diminish in size until they are lost, or to become plastic and unexpandable when treatment is completed. In either case a thoracoplasty usually follows. If a better cure is first obtained in this manner, it is still justified, providing the thoracoplasty was contraindicated in the first place. Some physicians fill an extrapleural pocket with oil or wax, but due to frequent complications from these substances acting as a foreign body and causing fistulae, the treatment (though often effective) is not a popular one.

Lucite spheres are sometimes used to maintain this type of extrapleural pocket. Experience has shown, however, that when a permanent collapse is desired, these spheres should not be used, as sooner or later they will have to be removed before they, too, acting as a foreign body, cause complications.

I believe that the most controversial of all treatments at the present time is pneumoperitoneum. Enthusiasts use it for nearly every case, while in some parts of the country it has been completely discarded. Both pneumothorax and pneumoperitoneum allow relaxation of the tuberculous lung. Neither involves the shock and trauma of thoracoplasty or resection. When indications require more than bed rest, but are not sufficient for major surgery, pneumothorax or pneumoperitoneum have their uses. Pneumoperitoneum has certain advantages over pneumothorax in that it is completely reversible and is accompanied by fewer complications. On the other hand, it is less selective and specific.

Pneumoperitoneum is useful in controlling acute lesions and preparing them for surgery, as well as in cases with rather limited amount of pathology which need more than bed rest alone, particularly those with bilateral lesions. Chemotherapy has to some degree supplanted this particular use of collapse or completely replaced it in some institutions.

Some surgeons are now using pneumoperitoneum following resections until they are reasonably sure that all remaining foci have healed. Pneumoperitoneum may be combined with phrenic crush but the advantage gained may not be sufficient to risk the sequelae of the temporary phrenic as to impairment of function, particularly if the diaphragm should remain permanently paralyzed. Chemotherapy may now be more effective than phrenic crush in controlling acute lesions, and certainly surgery offers more than pneumoperitoneum for the cases with chronic advanced lesions which can be safely operated upon. I feel that pneumoperitoneum is a useful treatment for tuberculosis only when its limitations are recognized.

Thoracoplasty has been for many years the favorite operation for pulmonary tuberculosis. As a primary measure it is used for apical lesions which would not be expected to respond to pneumothorax and yet do not contain enough scar tissue to prevent collapse. Unsuccessful collapse or poor results with pneumothorax, extrapleural pneumothorax, and plombage usually require thoracoplasty. Combined with resection to prevent exacerbation of contralateral lesions, it has made lobectomy and pneumonectomy much safer procedures. The use of thoracoplasty is for the most part limited to collapse of the upper third of the lung. It should not be used where resection is indicated for caseous areas and those in which by reason of location or amount of scar, a good collapse is not anticipated.

All of the above methods of collapse therapy meet our criteria for successful treatment within their own limitations. In general, pneumothorax, pneumoperitoneum, and thoracoplasty give the best results in well selected cases. However, they should never be used as a compromise treatment when indications are in favor of resection rather than collapse.

### Resection

So few long-time follow-up studies of resections are available that it is difficult to evaluate final results. From work which has been reported, it would appear that primary resections are indicated in those patients with positive sputum who (1) have caseous foci which would not respond to collapse therapy, (2) have cavities with too much scar and too thick walls to be succesfully collapsed, (3) have tension cavities (whether sputum is positive or not), and (4) have bronchial disease with stenosis distal to the proposed site for amputation.

Following unsuccessful collapse of diseased lung by thoracoplasty, resection also should be considered. For the above types of disease resection has proved to be quite valuable.

A new use for resection has recently been introduced for those cases containing caseous foci which have been treated for a long period with streptomycin. They appear to be under control. X-rays are stationary, and sputum, though chemotherapy is continued, remains negative. Statistics have been quoted to show that 30 to 50 per cent of these cases will become reactivated. To prevent this from occurring, wedge resections have been done on a large number of cases. When the removed sections were examined, many tubercle bacilli were found. These bacilli did not reproduce on culturing in the first series of cases reported. However, more recently viable bacilli have been found and cultured from specimens removed after short term therapy.

It is far too early to evaluate this last procedure. We must realize that the percent of cases who relapsed after therapy before streptomycin was discovered was much less in most institutions. This shows that the term "reactivated" as applied to streptomycin cases is a misnomer—they were probably never inactive to begin with. It has always taken several years for tuberculosis to heal. We are all getting too impatient and expecting too quick results. I am not saying that these wedge resections are not good therapy—they may be and probably are—but I do feel that we should proceed slowly in discontinuing established and proven types of treatment in favor of a full sized

program consisting solely of streptomycin followed by wedge resection. Streptomycin may be a two-edged sword which serves to control tuberculosis, but at the same time delays the development of individual immunity and the natural healing progress. Whether this is true or not, streptomycin can give us a false sense of security when it is acting temporarily upon the tubercle bacillus and any surgical program based upon such premature evidence may be too all-inclusive to be practical. The pendulum has swung wide for the present, which is the best way to learn. It may swing back to some extent when we have had more experience.

### Chemotherapy

So much has been written concerning chemotherapy with which you are familiar that I will pass over the well-known preparations quickly. To date, the chief value of all of them is to reduce the number of bacilli and prevent dissemination of the tuberculous lesions. They are most effective in acute exudative cases and bronchial lesions, and, when combined with collapse therapy and resections, have been highly effective in checking the progress of the disease and preventing potential spread. It must be remembered that there is no proof that they are bactericidal as yet and they should not be used with this expectation.

The position of streptomycin, dihydrostreptomycin and PAS in chemotherapy has been well established. Tibione has been disappointing; terramycin has shown some possibilities, not yet convincing; viomycin is not impressive but it could be used in streptomycin-resistant cases; aldinamide is less toxic than some of the other drugs but resistance develops very rapidly when it is used independently. Mycomycin, because of the difficulties of production, has been abandoned.

Until recently, short term periods for chemotherapy were considered relatively safe and effective. However, by using combined therapy such as streptomycin twice weekly and PAS daily, we have found that resistance does not appear for a much longer period. This allows then for much longer intervals of chemotherapy, which may be much better than the previous system. Following short term courses of therapy during which the sputum turned negative, all too often it reverted to positive two or three months after treatment was discontinued. Animal experiments done by Dr. Steenken at Saranac, and by Dr. C. Richard Smith at the Barlow Sanatorium, indicate that following the discontinuance of therapy, the treated animals which had done fairly well during treatment retrogressed faster than the controls at the end of treatment, which might be indicative of the fact that while chemotherapy diminishes the number of bacilli and prevents dissemination, it may not be effective in assisting the patient to build up his own immunity to the disease. Originally there were so many optimistic reports on conversion of sputum with chemotherapy, that the American Trudeau Society found it necessary to publish a bulletin, warning physicians not to consider a patient to be negative unless the tests were done three months or more after the discontinuance of treatment.

About the twenty-second of February, a news story broke in the New York papers which was immediately taken up by magazines, and press services flashed it around the world. A new cure for tuberculosis had been discovered and was being used at Sea View Hospital. Terminal cases were cured in a few weeks and the fight against tuberculosis was at an end. This gross misrepresentation and departure from actual facts dealt the whole tuberculosis control movement a serious blow. The public now believes that we can cure this disease, and those who furnish beds for hospitals are inclined to hold back any further appropriations until the need for beds can be redemonstrated.

These new substances are isonicotinic acid hydrazide, a synthetic substance with the general formula of $C_6H_7N_3O$, and its isopropyl derivative. This compound is not new, as it was synthesized many years ago; but a use for it had not been found until the two pharmaceutical houses of E. R. Squibb & Sons, and Hoffman-La Roche, Inc. started individual investigations of its possible uses in tuberculosis. Simultaneously Dr. Walsh McDermott at Cornell Clinic started using the Squibb preparation, and Drs. Robitzek and Selikoff at Sea View used the Hoffman-La Roche product. Neither knew the other hospital was working on the same formula. It was found that this drug has a bacteriostatic effect against Mycobacterium tuberculosis in very low concentrations in vitro. In animal experimentations it appeared to approximate the therapeutic equivalent of streptomycin. It appears to have relatively low toxicity in dosage that would appear to be effective. It can be produced commercially at a very reasonable price. While relatively few toxic effects have been noticed, this drug is excreted by the kidneys, which should be carefully checked for renal damage and retention before therapy is started; otherwise, blood levels may become so high that they will reach the danger level for toxicity. Blood urea nitrogen tests should be made at safe intervals throughout the period of treatment.

In checking the results of the Sea View cases which had been on treatment only a few weeks or so at the time a report was made, it was found that these patients had gained weight, their temperatures had dropped and they had a feeling of well-being. The x-rays, however, showed little or no change, and the laboratory work on the sputum was so incomplete that it was difficult to appraise the effect.

The *American Review of Tuberculosis* for April gives an account of the knowledge we have to date on this drug. The only additional information I can give you is what was reported at the Annual Meeting of the California Tuberculosis Association the first of this month. At that time, papers by Dr. Lawrence D. Hobson of New York and Dr. H. Corwin Hinshaw of San Francisco discussed their experiences with Nydrazid. Their reports were not as glowing as the Sea View reports, but they were encouraging. It was reported, however, that the bacilli become resistant rather rapidly to Nydrazid, and it was suggested that combined therapy with streptomycin or PAS would be advisable. No one has yet used the drugs long enough to determine whether sputum converts to negative or not although the amount has apparently decreased in a great majority of cases treated, and a few of the Sea View cases turned negative on direct smear and concentration. It is believed that this compound or some of its derivatives will permeate into the spinal fluid and reach the same concentration level as it does in the blood. If so, they should be of greater help in meningitis cases. For pulmonary disease, a safe dosage appears to be 200 mg. per day for patients weighing from 140 to 150 lbs. It is tolerated better if divided into three or four doses, although blood levels do not appear to have any great significance, provided, of course, that they do not reach toxic proportions.

As it is necessary for the pharmaceutical companies to have their own trade names for the products, you will find some of them as follows. For isonicotinic acid hydrazide, E. R. Squibb & Sons have Nydrazid; Hoffman-La Roche, Inc., have Rimafon; the isopropyl derivative, which appears to be many times more effective in vitro, is called Marsilid under the trade name of Hoffman-La Roche. Other companies now putting out isonicotinic acid hydrazide are Schering Corporation with Ditubin, Nepera Chemical Co. with Pyricidin, and Panray Corporation with Isonizede.

There is so much yet to be learned concerning the results of this therapy that it is impossible to evaluate it. There is no knowledge at the present time to indicate that isonicotinic acid hydrazide or its isopropyl derivative will accomplish more than has been accomplished with streptomycin and PAS. It may, however, prove to be an additional drug of great value. There is at present no basis for expecting that this or any other drug available can safely be counted upon to reduce the duration of hospitalization or to do away with our need for hospital beds.

## Conclusion

In conclusion I wish to say that any trend away from bed rest at the present time is premature. The various types of collapse therapy that have been used throughout the years are still indicated in well selected cases. The worth of these procedures has been proved beyond any doubt, although the indications have narrowed. With the addition of resection to our methods of treatment, we now have ways of treating individuals who would not respond to collapse therapy. Resection is well established for certain types of cases, but sufficient follow-up studies have not been carried on long enough to evaluate all of the purposes for which resection is being used. Chemotherapy is a valuable aid and adjunct to treatment. If it is used indiscriminately, which I feel it is, there may be times when it does more harm than good. The temptation to use chemotherapy in every case at the demand of the patient himself has complicated the whole picture of therapy, and it will still take many months, and possibly years, to completely evaluate the effects of chemotherapy upon the tubercle bacillus, its metabolism and the host. In the meantime it is to be hoped that a specific drug, bactericidal in nature, will be found which will actually cure tuberculosis. Such a drug could even be used on recent tuberculin converters.

Even then, destroyed lung will not be replaced, and the beds for medical and surgical care will still be needed. The money given to research is beginning to pay dividends. Let us hope that the great discovery may be made soon so that, combined with our control methods, we may live to see the elimination of this disease.

# The Cutaneous Manifestations of Internal Diseases

HAROLD M. JOHNSON, M.D.
HONOLULU

THE general practitioner, internist, and dermatologist are aware of the many varied skin reactions of systemic disease. The skin is known to be a mirror of metabolic and infectious processes. The objective findings follow a fairly specific pattern of the various disease entities, such as the viruses, drug sensitivities, tuberculoderms, syphilis, and collagen diseases. Early recognition and therapy may save the patient countless hours of pain, expense of drugs, hospitalization and therapeutic fumbling. A cutaneous change may signify an early systemic disease. In some fatal diseases, the skin may give the first warning of impending disaster: e.g., the pruritus of the lymphoblastomas, the petechiae of the blood dyscrasias, or the pigmentary eruptions occurring with some malignant tumors.



DR. JOHNSON

The skin is not a mantle or cloak separate from the rest of the body but functions as an integral part of the vascular, hormonal and central nervous systems. It is also a field of bacterial commensaalism, symbiosis and defense (immunologic).

## Metabolic Diseases

*Xanthomas:* The exact etiology of the xanthomas is unknown, not all are associated with hyperlipemia, and they may occur without liver disease.[1] Various hormones in the pituitary and thyroid glands, pancreas and the sex glands are closely related to lipoid metabolism.

Xanthomatous biliary cirrhosis is an independent clinical syndrome, occurring together with plane and tuberous xanthomas of the skin, xanthoma formation in the intima of the blood vessels and the endothelial lining of the bile ducts in association with hepatic disease that is secondary to obstruction of the common bile duct, especially as the result of postoperative stricture.

Diabetes mellitus produces such dermal changes as the xanthomas, vaginitis and carotenemia and should be recognized as readily by its polyphagia, polydipsia, and polyuria. The accumulation of sugar in the skin may produce irritation and pruritus or may create a perfect medium for the growth of the ubiquitous yeast (Candida albicans).

Xanthelasma or the soft yellow (chamois) xanthoma infiltration above and below the eye may be the first sign of impending cardiovascular disease, hypertension or arteriosclerosis. In about 70 per cent of the cases there is moderate to marked elevation of blood lipids, especially cholesterol and total lipids.

*Nutritional diseases:* Avitaminosis or nutritional diseases produce dermal changes that are characteristic. Vitamin A deficiency shows a follicular hyperkeratosis and a generalized dryness of the skin. The spinous papules are at the site of hair follicles, localizing over the arms and thighs. The nails may show transverse ridging and pitting.



FIG. 1.—Xanthoma lesions showing firm pale yellow papules. Patient had xanthomatous biliary cirrhosis.

Vitamin B deficiency disorders are the result of inadequate intake or utilization of niacin and riboflavin. The scaling of the lips, red tongue and cracking at the corners of the mouth (perléche) suggest riboflavin deficiency. The skin lesions of pellagra are rare but it has occurred in Hawaii. I remember an old Hawaiian woman who had restricted her diet to rice for many months. She had the dark bark-like pigmentation on the back of the hands, scaly reddish brown changes around the neck (Casal's collar). The tongue was magenta

Read before the Sixty-Second Annual Meeting of the Hawaii Territorial Medical Association, May 2, 1952.

[1] Thannhauser, S. J.: Serum Lipids and Their Value in Diagnosis, New Eng. Jr. Med. 237:518 (Oct. 2) 1947.

in color and smooth. Photosensitization and consequent damage from sunlight undoubtedly play an important part, as the major cutaneous changes occur on the exposed areas of the hands, arms and face.

The pruritus of liver damage plus icterus of skin may be the first sign of faulty liver metabolism, also in liver disease, angiomas (spider angiomas) may appear on the face, neck, chest and abdomen. This is a small bright red nevus with central elevation and minute spider-like capillaries extending like tentacles.

### Endocrines

Recently I saw a case of Cushing's disease through the courtesy of Dr. M. E. Berk. The patient presented hirsutism, considerable acne of the back, buffalo hump of the shoulders and large abdominal striae distensae (purplish-red). Mild diabetes, hypertension and excessive weight increase contributed to the syndrome. A unilateral adrenal tumor was found on surgical exploration.

In Addison's disease, the skin changes of bronze to a brown pigmentation may appear on the hands, face, axillae, groin and scrotum.

Acne is certainly an endocrine problem for either sex. The child may have a perfect skin before the puberty-adolescence period but the inexplicable trigger mechanism of the estrogen-androgen relation produces the menstrual and periodic exacerbations.

Circumscribed myxedema or pretibial edema may occur in two forms. The first type is papular, nodular and diffusely infiltrative involving the face, scrotum, arms and back. The common type is nodular, irregular, elevated, non-pitting plaques on the shins. Many of the cases appear after thyroidectomy and are associated with hyperthyroidism. Curtis et al.[2] believe that localized myxedema so strikingly simulates the course of progressive exophthalmos that one must accept the belief that these two conditions are allied manifestations of the same disease. Localized myxedema usually occurs with toxic diffuse goitre and thyroidectomy or thiouracil therapy.

Herpes gestationis is a troublesome recalcitrant disease occuring from the third month of pregnancy until term. The pruritus at times can be almost unbearable. In others, the itching is bothersome but can be controlled. The grouped papules, vesicles and even bullae appear on the abdomen, groins, breasts and extremities. I have seen cases, misdiagnosed as scabies, aggravated by antiscabietic therapy (contact sensitization). This syndrome appears to be a variant of dermatitis herpetiformis.

### Genetics

Defects of germ plasm may manifest themselves in various conditions. They may be present at birth or occur later in life. The clinical findings can be minimal as a constricting band around a finger,[3] legs or a severe case of congenital ectodermal defect suggesting the clinical picture of congenital syphilis.

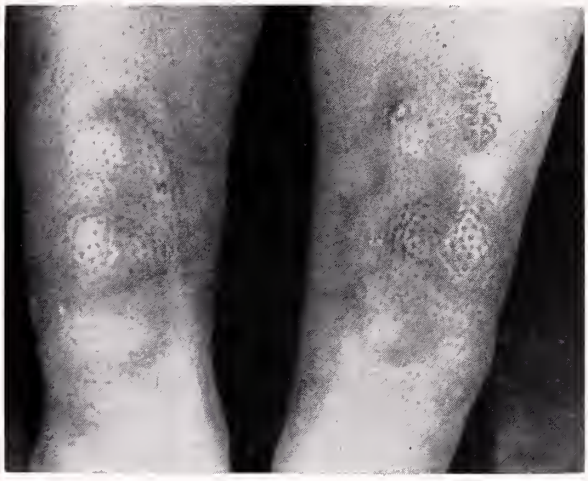


FIG. 2.—Circumscribed myxedema following thyroidectomy. Non-pitting infiltrated plaques usually occurring on the legs.

Xeroderma pigmentosum can be summarized as a precocious development of "sailor's skin" with keratoses and basal and squamous cell carcinomas. It appears sometimes at the end of the first year of life. It is directly associated with sunlight. All exposed areas, as the face, arms, hands and neck are involved. Death usually occurs between the age of 15 and 18 years from malignant metastases.

Keratosis follicularis (Darier's disease) is a rare congenital disease that causes discolored, warty, papular excrescences, which tend to coalesce into patches on the face, trunk and flexures of the extremities. The disease can be disfiguring to the facies, crippling because of large papillomatous growths about the anogenital and axillary areas.

Epidermolysis bullosa is a peculiar hereditary condition of the skin characterized by the development of vesicles and bullae occurring on minimal trauma. Histologically, there is a deficiency of elastic fibers of the skin, resulting in increased vulnerability.

I can vividly remember a boy with epidermolysis bullosa who showed multiple scars of old areas of

[2] Curtis, G. C., Cawley, E. O., and Johnwick, E. B.: Association of Progressive (Malignant) Exophthalmos and Localized Myxedema. Arch. Derm. and Syph. 60:318 (Sept.) 1949.

[3] Johnson, H. M.: Congenital Cicatrizing Bands. Report of Case with Etiologic Observations, Am. J. Surg. 52:498 (June) 1941.

trauma, recent infected crusts on all areas of prominence as the knuckles, elbows, knees. He also had a partial loss of oral mucous membrane. Nutrition was difficult because the child could only swallow liquids and semi-solid foods. Treatment is valueless.

Neurofibromatosis is a familial disease, presenting areas of pigmentation and tumors—either small pendunculated tumors or large growths called fibroma pendulum. Occasionally, neurofibromatosis may be associated with alopecia, epilepsy, feeble-mindedness and dementia praecox.[4]

### Infections

Bacterial infections produce varied eruptions that are fairly diagnostic. In children, the exanthems of measles, scarlet fever and varicella are easily recognized, but in the adult, they are often mistaken for other diseases.

Meningococcal meningitis or cerebrospinal fever manifests itself in part by petechial hemorrhages or purpura. The lesions appear on the legs, palms, soles, mouth and eyes. The skin rash has been recognized as one of the earliest clinical signs of meningococcemia. Some of the purpuric areas may become necrotic and slough, as seen in gangrene.

The Waterhouse-Friderichsen syndrome has a classic history, symptoms and sequence of events placing it as a definite entity. Most of the cases are seen in children under the age of two years. It is not infrequent in adults. The first symptoms are headache and vomiting, malaise. Temperature may go to 107° F. Cyanosis of the lips, nails and skin may occur. Petechiae follow the cyanosis and may be small pin point macules to large areas of purpura. The hypotension is severe, as is to be expected in vascular collapse caused by adrenal apoplexy.

Virus infections of the skin are becoming prominent in the medical literature. Herpes simplex is a childhood infection that remains latent in the skin and for some inexplicable reason the "trigger mechanism" is set off resulting in the mild fever, vesicles and even adenopathy. This may be a recurrent affair, usually occurring near or in the same area of tissue.

Kaposi's varicelliform eruption is thought to be a generalized herpes simplex on an atopic (allergic) eczema. It is difficult to differentiate this eruption from eczema vaccinatum. In the latter there is a history of recent smallpox vaccination, or contact with a recently vaccinated person. The typical lesion is a grouped vesicular-pustular plaque with central umbilication. This disease can be fatal.

### Malignancy

The cutaneous signs of intestinal polyposis are most striking on the lips, buccal mucosa, fingers and toes. The lesion is a blue-black freckle varying from 1 to 5 mm. in diameter. Jeghers et al.[5] found this sign of diagnostic importance in 10 cases of intestinal polyposis. The polyps are distributed throughout the entire intestinal tract with striking clinical manifestations in the small intestines. The polyps may or may not be malignant. A patient seen with blue-black freckles on the face, especially on the lips, buccal mucosa, fingers and toes, associated with symptoms referable to the small intestines—abdominal pains, signs of minor obstruction and intussusception — would highly suggest intestinal polyposis.

Acanthosis nigricans is a disease of chromaffin insufficiency. It is a rare skin reaction that may develop slowly and insidiously or rapidly. The flexures of the face, lips, mouth, nipples, and axillae are common sites, although no region is exempt. The skin becomes darkened, velvety, furrowed thickening. The areas may have soft papillomatous excrescences. Hyperkeratosis of the palms and soles is a common accompaniment. In an adult, it is an ominous sign of an internal cancer. Fifty per cent of the patients have cancer and over 90 per cent of the cancers are abdominal, usually gastric, glandular and highly malignant. In the juvenile type, under 18 years of age, it is benign and only a cosmetic problem. In acanthosis nigricans in a woman over 30 years of age, an abdominal exploration is imperative.[6]

Lymphoblastomas are a specific group of neoplastic diseases originating in the hematopoetic, lymphoid and reticular tissue. The various types are closely related, and transitions from one into the other have been reported.

The chief types are lymphosarcoma, leukemias, Hodgkin's disease and granuloma fungoides. These diseases are of considerable interest to the dermatologist, as the earliest manifestation of the disease may be an intractable pruritus that has been present for months or years. It is an unwritten law in dermatology that one should be suspicious of an early lymphoblastoma when a patient has an unexplained exfoliative dermatitis with pruritus—especially after 50 years of age.

[4] Downing, J. G.: Cutaneous Manifestations of Systemic Diseases, Am. Jr. Pract. 3 (July) 1949.

[5] Jeghers, H., McKusick, V. A., and Katz, K. H.: Generalized Intestinal Polyposis and Melanin Spots of the Oral Mucosa, Lips and Digits, New Eng. J. Med. 241:1031 (Dec. 29) 1949.

[6] Sutton, R. L., and Sutton, R. L., Jr.: Handbook of Diseases of the Skin, St. Louis, C. V. Mosby Co., 1949, p. 409.

The sudden appearance of herpes zoster, urticaria, purpura, papular-vesicular eruptions are a few of the early signs of a serious forthcoming disease. Infiltration of the skin with hyperplastic hematopoetic tissue occurs most frequently on the affections commonly designated granuloma fungoides, lymphatic leukemia and lymphosarcoma, less often in myelogenous or monocytic leukemia and Hodgkin's disease.



FIG. 3.—Acute systemic lupus erythematosus. Note the diffuse edema of the face, also seen in dermatomyositis and other collagen diseases.

Metastatic carcinomas to the skin develop, most frequently from cancer of the female breast and genitals or of the prostate gland. Several years ago, I saw a Chinese patient who had several discrete pea-sized ulcerated nodules of the nose, ears and trunk. He had been ill for sometime with a chronic gastritis. On surgical exploration, he had an inoperable adenocarcinoma of the stomach. The skin nodules showed the histologic structure of adenocarcinoma.

Metastasizing sarcomas vary tremendously in their rate of growth. A single tumor may start in an insidious manner and later become fungating masses and generalized. I have never seen a case of cutaneous metastatic sarcoma.

Acute systemic lupus erythematosus is a serious systemic disease with an obscure etiology. In the acute systemic form of lupus erythematosus the onset may be gradual, with fatigue, loss of appetite, joint pains and weakness. This transition may be gradual or explosive in type with a fulminating course and death. The prognosis of the acute type is grave. The mortality has been listed as high as 100 per cent.[7]

The typical cutaneous lesion is the butterfly shaped erythema extending over the bridge of the nose to the cheeks. The erythema and edema are at times hardly recognizable, and at other times the lesions are swollen and erysipelas-like in appearance. A variety of polymorphic lesions may be noted in the skin and mucous membranes, including crusted, hemorrhagic, papular and pellagroid changes.[8]

The systemic manifestations include anemia, leukopenia, thrombocytopenia, fever of the septic type, adenopathy, arthralgia, pleurisy, pericarditis and endocarditis. Severe kidney damage is usually found.

Hargraves[9] and Haserick[10] have devised a specific test for the differentiation of chronic discoid lupus erythematosus and the acute systemic type. The "L. E." cell has been found in tissues and other body fluids beside the blood and marrow in the acute and chronic systemic form of lupus erythematosus. The test has been a valuable diagnostic aid in differentiating this disease from other systemic diseases.

### Sarcoidosis

Sarcoidosis is a systemic disease, following a chronic course and having characteristics of a benign infection, although it can be fatal. The anatomical locations of the disease are apparently numerous. Sarcoid examination is not complete without a careful study of the mucous membranes and skin. The superficial nodes and palpable glands as well as the eyes and small bones of the extremities should be examined, and roentgenologic studies of the thorax, hands and feet are imperative.[11] The histologic examination should be diagnostic of sarcoid architecture. Michelson

[7] Montgomery, H.: Symposium on Lupus Erythematosus, Proc. Staff Meet. Mayo Clinic 15:678 (Oct. 23) 1940.

[8] Rose, E., and Pillsbury, D. M.: Lupus Erythematosus (Erythematodes) and Ovarian Function: Observation on a Possible Relationship with Report of Six Cases, Ann. Int. Med. 21:1022 (Dec.) 1944.

[9] Hargraves, M. M.: Production in Vitro of L.E. Cell Phenomenon: Use of Normal Bone Marrow Elements and Blood Plasma from Patients with Acute Disseminated Lupus Erythematosus, Proc. Staff Meet. Mayo Clinic 24:234 (Apr. 27) 1949.

[10] Haserick, J. R., and Bortz, D. W.: New Diagnostic Test for Acute Disseminated Lupus Erythematosus, Cleveland Clin. Quart. 16:158 (July) 1949.

[11] Michelson, H. E.: Sarcoidosis--A Review and an Appraisal, J.A.M.A. 136:1034 (Apr. 17) 1948.

doubts whether a diagnosis of sarcoidosis can be accepted without microscopic evidence.

Skin lesions may be found in 40 to 50 per cent of cases.[12] Many forms have been described, including the miliary nodular sarcoid, diffuse, plaques, and erythroderma. The lesions may remain for long periods or may spontaneously regress in a course of a few months.

### Conclusion

The skin has been catalogued as a mirror of internal disease. The skin may show the initial changes of anemia, systemic infection, metabolic disease, endocrine disorders and malignancies.

The relation of systemic disease and its cutaneous changes are becoming more apparent to the general practitioner and internist and in other specialized fields of medicine. The knowledge and early recognition of diagnostic signs and symptoms are helpful to all physicians who may practice the art of medicine.

It is the aim of this paper to briefly summarize a few of the more important systemic diseases with cutaneous manifestations.

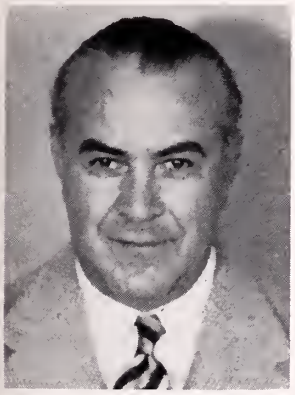
[12] Freiman, D. G.: Sarcoidosis, New Eng. J. Med. 239:709 (Nov. 4) 1948.

Young Hotel Building

# Observations on Mental Illness and Crime

MARCUS GUENSBERG, M.D.*
KANEOHE

MAN is not born with criminal propensities, nor is there conclusive evidence to assume that he is born with tendencies to develop a mental illness, barring some rare organic brain defects determined by hereditary factors. Crime and mental illness are chiefly products of environmental forces and influences which to a large extent are controlled by man. One of the most important environmental sets to shape human character and mold man's personality is the home and its emotional climate, the parents and the way they relate to their children, the siblings the child grows up with; in brief, the physical and the emotional structure of the family. If those influences are sound and wholesome, if they provide the growing youngster during his formative years with love and security, a feeling of belonging and being wanted, if they satisfy his needs for self-expression, achievement and approval, then the youngster will go through the various stages of emotional, psychosexual and social growth and development in a normal fashion and in the proper chronological order and in due time reach emotional, sexual and social maturity.



DR. GUENSBERG

### Origin of Neuroses

On the other hand, if his early childhood is disorganized and disrupted, if the normal processes of growth are interfered with by, let us say, a cruel and punitive father or by a domineering or over-indulgent mother, or by a malignant sibling rivalry fostered by favoritism on the part of the parents, or if the child is denied the warmth and the security of a home, or for that matter the essentials of life like food, clothing and shelter, then the youngster will experience privations and frustrations producing a profound sense of insecurity stemming from a feeling of being rejected, which—in his imagination—may amount to a real threat to his very survival.

In that setting, the child will experience tensions and fears, coupled with resentments and hostilities towards those whom he considers—consciously or unconsciously—culpable for his plight. Those antagonistic feelings and attitudes towards his parents or siblings, whom he should love according to custom, tradition and the dictates of his conscience (superego), generate feelings of remorse and guilt which are in direct ratio to the intensity of the resentments and hostilities frowned upon by society. And the direct and immediate outcome of this constellation of conflicting emotional forces will be a state of inner tension and distress that we call "anxiety" and which we have learned to recognize as the cardinal symptom of neurotic illnesses and the point of departure for a chain of events that make up the multiphasic patterns of neurotic behavior.† Those anxieties, if not remedied or attenuated, will often become ingrained in the child's personality structure and produce neurotic illnesses like phobias, compulsions, depressions with self-destructive fantasies, or some undesirable character traits which may become incapacitating liabilities. Some of these people will eventually resort to alcoholism or drug addiction as a style of life, in order to relieve their anxieties, to keep in check their fears and hostilities, or to derive vicarious gratifications of their repressed emotional needs in an alcoholic setting.

### Psychosomatic Disorders

In numerous instances, the emotional state of distress and anxiety may prompt the body to go into defensive action, diverting those emotional impulses into somatic channels, into selected organs or organ-groups, via the autonomous nervous system, the highway that connects our mental life with body functions. This process of somatization, this mechanism of "squeezing emotional energy into body tissues" (Hinsie), then gives rise to a multitude, and kaleidoscopic variety, of somatic phenomena. At first those aches and complaints reflect only minor functional disturbances which in due time, however, may well lead to structural changes making up a substantial group of human pathology. We are now only beginning to recognize and to appreciate the role those mechanisms play in the medical sciences.

* Formerly Medical Director, Territorial Hospital. Dr. Guensberg died July 11, 1952. See Obituary, page 49.

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† This formulation is not intended to preclude other possible sources or origins of anxiety.

One may well anticipate a time when the contribution made by Selye, who gave us the concepts of the G-A-S (General Adaptation Syndrome), comprising the "alarm-reaction," the "stage of resistance" and the "stage of exhaustion" and reflecting the disturbances and adjustments in our hormonal adaptation-mechanisms, will be correlated with the knowledge gained by psychiatry in regard to conversion and somatization phenomena, designed to arrest or to reduce anxiety by draining it off into soma. Psychosomatic concepts that will then evolve may well provide the answers to many a baffling question of today. As a matter of fact, we are beginning to discern the making of a synthesis of physiological medicine on one hand and of the psychological side of our existence on the other hand, a synthesis that may well pave the way towards a clarification and unification of certain fundamental principles applicable to all aspects of human existence, to the entire human phenomenology, in growth or decline, in childhood or old age, in health or disease, in life or its cessation. Such a synthesis will ultimately solidify our present concept of the wholeness of man, since it is always "the whole man," indivisible, that thinks, feels and acts in unison, that is ill and suffers, that fights or flees, or that commits a crime or breaks mentally.

### The Psychotic Disorders

In a large number of cases, mental illness is clearly a defense mechanism of the entire man, the end-product of an unsuccessful adaptation syndrome that causes the individual to resort to disorganized, bizarre and often anti-social behavior-patterns in his dealings with life and its realities. This concept is best illustrated by those who, if hurt and frustrated, will cope with their fears and anxieties by retreating, by withdrawing, by running away from a harsh and cruel environment into a world of day-dreams and fantasies. They will cringe and shun the environment that hurt them. They will become overly quiet, timid and seclusive.

If this process is allowed to continue, they will eventually withdraw from reality more and more, give up the struggle, and lean heavily on day-dreams and inner fantasy life as the only source of gratification and enjoyment. Before long, they will lose touch with reality altogether, with distorted wish-fulfillment fantasies taking its place, characteristic of a schizophrenic breakdown, one of the most serious psychiatric disorders. In all those instances, be it a pattern of neurosis or alcoholism, or an illness of psychotic proportions, the individual breaks under the impact of malignant environmental forces and traumatic experiences without ever really coming to grips with the problems and conflicts that generate his abnormal behavior patterns, except for some scattered, feeble and ineffectual efforts to alter the environment.

### Delinquency and Crime

Then there is another group of youngsters who respond to the frustrations and insecurities of early childhood and to the anxieties arising therefrom by mobilizing all the resources at their disposal, limited as they may be, by getting ready for a fight, by striking back, by using violence if need be, by "acting out" their hostilities. All those mechanisms of defense and attack which will vary from case to case, are primarily designed—largely on an unconscious level—to alter and change the traumatic environment and the threatening social influences and in doing so to gain some sort of attention and security which have been denied to him. What the youngster could not gain legitimately, he will try to gain—in his immature and crude fashion——by illegitimate means, by indulging in acts which society frowns upon, by resorting to a hostile-aggressive behavior pattern, which is at the root of delinquency and crime.

This hostility may in some cases manifest itself in the form of what has been described as passive-aggressive patterns, like pouting, stubbornness, disobedience, defiance, truancy, etc. But if these forms of behavior prove insufficient to cope successfully with his problem, to relieve his anxieties and to give him a sense of security, the youngster will resort to more malignant forms of nonconformity and rebellion, to outright anti-social actions. He will become actively aggressive, that is, belligerent, destructive, and openly defiant, breaking conventional standards and codes. To "get even" with the adult world he will resort to various acts of juvenile delinquency, like stealing, robbing, vandalism, or indulging in abnormal sexual practices—which as a rule he or she does not enjoy—violating all the rules, traditions, laws and statute, fighting society on a broad front.

To understand this pattern of behavior, one must keep in mind that such a youngster never had and never knew what we call a positive parental figure with whom he could and would identify. He never knew an adult to be kind, considerate, looking after his needs, helping him in hours of stress, and serving him as a model and example to follow and to emulate. His parents, if present, or his parent substitutes, were harsh and crude and punitive, and by a process of comparison and identification he will attribute the same unsavory characteristics to every adult, particularly to an

adult with authority, like teacher, social worker, policeman, probation officer, or foster parent for that matter. If that pattern is allowed to persist, unchanged and unmodified, then the relatively innocuous type of juvenile delinquency will eventually lead to a pattern of crime including rape and murder.

### What about our juvenile delinquents?

It is this large group of youngsters that keep our social agencies constantly busy. They are handled by child welfare agencies first, they come to the attention of the juvenile courts via the police, they are sent to detention-homes and reformatories, they keep our probation officers busy, they discredit foster homes and cause a great deal of grief to well-meaning yet unprepared foster parents, and to all those who, at this late hour, are trying to look after their needs. They eventually fill our jails and prisons.

All those tragic consequences come about simply because we too often fail to recognize the early phases of those emotional disturbances, their causes and their motivations, and, when we recognize them, we fail to take the only action that holds promise and hope. Instead of realizing that we are primarily dealing with an emotionally disturbed youngster who is in need of help and guidance, we too often choose to look upon him as a "juvenile delinquent" who deserves confinement and even punishment. Instead of adding another punitive action to a career saturated with punishment, we will have to learn the art—and this is a concept corroborated by our present-day knowledge of the dynamics of human behavior—of approaching these youngsters in a spirit of permissive acceptance and understanding; of allowing them to ventilate their grudges and grievances; of making a genuine effort to modify the environment they stem from, if it is at all modifiable; of providing them with positive parental figures they could identify with; of helping them toward a sound type of growing up in a significant and meaningful home, that is, an integrated environment that takes into consideration their physical, emotional and social needs. In other words, we must replace restrictive and punitive methods by truly rehabilitative-therapeutic procedures that will guide the youngster towards inner balance, peace of mind and sound citizenship instead of allowing him to drift into a career of mental illness or crime.

Lucien Bovet, the eminent Swiss psychiatrist and Consultant in Mental Health to the World Health Organization, has this to say in his excellent report prepared at the request of WHO as a contribution to the United Nations program for the prevention of juvenile delinquency and the treatment of offenders: "The primary aim of treatment is that of enabling a juvenile delinquent to build up stable and secure interhuman relations, the proof of a feeling of inner security which is itself a foundation for his moral independence and consideration for others, and without which no human behaviour can be truly adapted to the demands of society."

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# Fracture of the Carpal Navicular

COLONEL CARL M. RYLANDER, M.C., U.S.A.*
HONOLULU

IN the orthopedic care of young male adults, fracture of the carpal navicular (scaphoid, if you prefer) causes the loss of an immense number of man hours. This is a common injury and it is not hard to diagnose, so it should be recognized early and properly treated. If properly treated right after the injury, most of the fractures heal readily and leave no disability. If they are not treated early, the golden opportunity has passed and the treatment then becomes a problem.



COLONEL RYLANDER

## The Problem

The usual history in these injuries is that a young adult has fallen on his outstretched hands and has then developed pain in his wrist. This pain is in the mid-portion and to the radial side of the wrist. There is usually some swelling on the radial side of the dorsal surface, most marked over the anatomical snuff box. There is tenderness in this same area.

The patient usually thinks that it is a sprain and he may treat it himself with heat and possibly a sling. When it does not recover with this treatment, he then goes to a doctor for examination. Some patients go to the doctor right after the injury, and frequently they are told that it is a sprain and are given inadequate treatment. Occasionally an x-ray is taken of the wrist but even then, in a few cases, the fracture is not seen with the usual number of views taken. So frequently the fracture has gone for several months or even a year or two before the patient finally has an adequate x-ray examination and the fracture is seen. Had this same patient been treated by proper immobilization right after the injury he would have had good union in a few months at most.

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Read before the Sixty-Second Annual Meeting of the Hawaii Territorial Medical Association, May 2, 1952.

## Diagnosis

When a patient presents himself for treatment of a sprained wrist one should *always* think of fracture of the navicular and make every effort to rule it out. Watson-Jones states that all injuries of the wrist should be considered fractures of the navicular, until they are proven otherwise. This can be done by first getting proper x-rays and examining them with a magnifying glass. If no fracture is seen, even then the wrist should be immobilized in a cast for three weeks, if it looks clinically like a fracture; and at that time it should be rechecked with x-rays. If these do not show a fracture, then a fracture can be ruled out.

X-rays should be taken in three planes: AP, lateral and obliques. The fracture line is frequently seen in only one of the views and occasionally it is not seen in any of them, in the fresh case. In fresh cases, the fracture shows as a fine line. After a few months without immobilization, the x-ray shows a wide fracture line, which is fuzzy in appearance and may have a cyst-like space in it. This widened line is caused by absorption of bone due to movement at the fracture site. About half of the navicular bone lies in the plane of the distal row of carpal bones and the other half lies in the proximal row. Movement of the wrist causes a shearing motion at the site of the fracture.

Much older fractures show a smoother line of fracture but there is sclerosis of the bone at the edges. X-ray may show aseptic necrosis of one fragment. The one fragment appears denser because with atrophy of disuse, the remainder of the carpal bones become less dense and the proximal fragment of the navicular does not change because of its loss of blood supply, which does not permit the calcium to be removed.

## Pathologic Physiology

Fractures of the navicular may be conveniently divided into three groups: 1. those through the distal end of tubercle; 2. those through the waist and 3. those through the proximal end. None of these heals spontaneously without immobilization. Those through the distal end practically all heal readily with treatment. Two-thirds of those through the waist heal readily and one-third of those through the proximal end heal readily.

The variation in healing of these fractures is due to the variation of the blood supply of the various bones. The bone gets its blood supply through vessels going through foramina on the dorsal surface of the bone, along the ligamentous ridge. The number and position of the foramina vary with different naviculars. When most of the vessels enter the bone in the distal end, then the proximal end gets its blood supply from vessels runing through the substance of the bone, and, with fracture of the bone, these vessels are interrupted.

With the simple fractures of the navicular, another injury occurs: a trans-navicular perilunar dislocation. This usually consists of a dorsal dislocation of all the carpal bones except the lunate and the proximal half of the navicular; these remain in their normal relation with the articular surface of the radius. There is considerably more damage to the circulation in these injuries than with the usual navicular fracture so there is more danger of aseptic necrosis. They should be reduced promptly. Some suggest a prompt fusion of the navicular, lunate and capitate bones.

### Treatment

Treatment of fractures of the carpal navicular consists of *early complete and uninterrupted immobilization* until they are completely healed as shown by x-ray. At that time the cast should be removed and the patient permitted to use his wrist for three weeks. It should then be rechecked with x-ray for any evidence of the old fracture line, and if it has reappeared, the cast should be reapplied.

The cast should extend from just below the elbow to the distal palmar crease, so that the patient can use his fingers, including the metacarpophalangeal joints. The thumb up to the distal joint should be included in the cast. The wrist should be cocked up moderately and the thumb should be in a position of opposition, with the cast molded well around it. The wrist should be in radial deviation. Some describe the position as that of the clenched fist. The cast should be molded well in the palm of the hand and held down on the dorsal surface while setting so that it will fix the hand and wrist very well. Watson-Jones advises no sheet wadding, but I use just a little.

How long should this cast be left on? Until it shows the least sign of becoming loose or soft and not giving adequate immobilization. Then it should be replaced with another cast, but no movement of the wrist should be permitted with the changing of the casts. The wrist should be kept in a cast until the x-rays show complete obliteration of the fracture line. I really prefer Castex as this usually holds until the fracture is healed and x-rays can be taken through it. A certain time limit cannot be placed for the cast, but you must check with x-ray. Almost all of the fresh fractures heal with this treatment.

### Complications

In case of delayed union, what should be done? Many of them will heal with just immobilization. Some doctors prefer doing multiple drilling through the distal end into the proximal fragment, but this is not generally accepted. Some use a peg graft through the distal and into the proximal fragment. In doing this, the fragments should be pressed together so that they are not held apart by the graft. Some prefer two pegs instead of one, since this gives better fixation. If one graft is used, then it should be of good size, up to ¼ inch in diameter. Some like to have the scar tissue removed from between the fragments. Soto-Hall and Haldeman do this latter procedure and use two pegs of bone. Gordon Murray of Toronto uses a large graft. In his series of 100 cases he had 96 per cent union with good function. He thinks that poor results have occurred as a result of using a graft that is too small, and the operation's not being done properly. Campbell's Clinic Group remove the proximal fragment if its size is one-fifth or less that of the entire bone, viable or not; or if it is one-third in size and is not viable; if a graft has failed; or if the fragment is comminuted. Do not remove the wrong fragment; this has been done several times.

Watson-Jones feels that the proximal fragment should be removed if it is not viable, but this should be done early, within a few weeks. It does no good to remove it late. I certainly agree with this. In general the men at Campbell's Clinic do not advise the removal of the proximal carpal row, but I feel that it does work well in some cases. Patients subjected to this do not have a full range of motion, but if it is without pain, then it is better than a fused wrist. I prefer removing the three bones rather than just two, because otherwise they tend to get a radial deviation of the wrist.

Barnard and Stubbins removed the styloid process of the radius, with or without a graft, and thought that they had better results in healing and less arthritis. I have used it in a few cases, with complete relief of pain in some. I think that it may be indicated when the fracture line strikes the articular surface of the radius, in radial deviation of the wrist, and, if removal of the styloid process elminates this contact. Vitallium balls have

been used as a substitute for the navicular but it has not been too successful. We are doing some work with plastic replacement but it is too early yet to predict the final results.

When a case has gone to non-union and has developed a definite arthritis of the wrist, then what should be done? I know of only one method that will give a painless wrist and that is fusion of the wrist. When the radius is fused to the radial carpal bones, they still have supination and pronation and it is not as marked a handicap as some people think. I fuse the radius, navicular, lunate, capitate and multangular major, but do not fuse the metacarpals to the carpals. This does give a slight movement which tends to take up some of the jar with use.

At one time some doctors believed in immobilization for prolonged periods of time, a year and longer, even up to two years. At the end of that time however, the patient had developed stiffness of the wrist and often some arthritis and they still had pain in their wrist, even though they had good union. At the recent meeting in Chicago of the Hand Surgeons, one of the doctors advocated longer fixation.

### Summary

In summary then, think of fracture of the carpal navicular with any wrist injury. Look for the clinical signs and symptoms. Get the proper x-rays. Re-check with x-rays after three weeks. Treat all fractures with *immediate* immobilization, which should be *complete* and *uninterrupted* until healing is complete.

### Discussion

DR. J. WARREN WHITE: Some papers, such as this excellent one of Colonel Rylander, calling attention to some common error we are continuously making, should be included in every program of this nature. Another similar indictment on hip injuries which, while it is irrevelant as regards subject, belongs in this category of error is: "Every elderly person who falls and is unable to get up by himself has a broken femoral neck until proven otherwise."

Colonel Rylander in his work among young adults sees relatively many more fractured scaphoids than do we in civilian practice. Seeing so few, therefore, tends to put us off our guard and we forget that a persistently sprained wrist must be proven not to have a scaphoid fracture. The incidence of a combined fracture with the routine fractured wrist must not be overlooked and the scaphoid must always be scrutinized in such common injuries as Colles' fracture just as one always should check the radial head in all fractures of the proximal half of the ulna.

On examining the scaphoid structurally, one can readily see why it is the bone in the wrist most easily and frequently broken. While it is not as large as the os magnum, which is roughly cuboidal or spherical, it connects the more anterior proximal plane of the carpus with the more dorsal distal row, this receiving a strain not present in the other carpals.

The usual location of the fracture is at the so-called waist and fortunately there is, at the start at least, little displacement. The displacement subsequently occurs primarily to the dorsal fragment, which works its way dorsally and forms a painful projection, if not immobilized, on the dorsum of the carpus. It is the dorsal fragment which usually becomes necrotic and stands out as Colonel Rylander has shown us so well in his slides.

The subject has been well handled in this paper both as regards the incidence of the injury and the treatment. I agree in general but take exception to Colonel Rylander's statement that the diagnosis is easy in a great majority of the cases and the fact that it occurs need only be stressed. I do feel that the time limit as regards immobilization should be emphasized as it usually takes longer than the usual type of fracture of the long bones and belongs in the same category as necks of the femur where for the same reason (poor circulation) the healing period is prolonged. It is a wonder to me, in view of this poor circulation, that we do not have more trouble. The x-ray is the surest way of following the progress of repair. The skin-tight plaster (preferably the Castex variety) should be worn until there is good evidence of union. At the onset, it is well to tell the patient that he has an injury which will take months rather than weeks for healing to take place.

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(Signed)
W. L. Lawrence

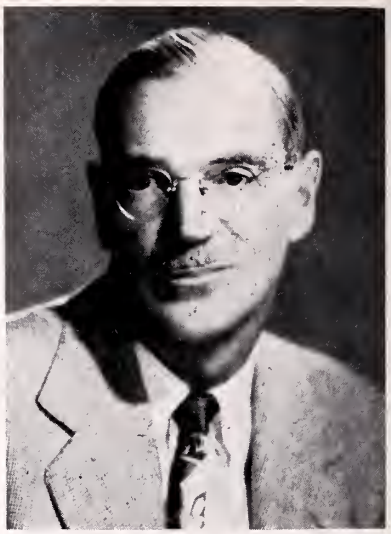
Mr. Lawrence is a Certified Public Accountant and the auditor of the Home. His letter points up one of the basic purposes of this institution—to provide "a sense of comfort and cheeriness"—both prime factors in convalescent progress.

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# *The President's Page*



## WHAT IS OUR AIM?

The expression "Hitch your wagon to a star" correctly suggests the impossibility of attaining all of our goals but we may well aim our sights high. To my knowledge no one to date has even made a trip to one of the planets in a horse and buggy. But there is no harm in selecting our star.

In this day the words "Paternalism" and "Dictatorship" are in common usage. Regarding "Paternalism" we are advised as to which star we should choose. Regarding "Dictatorship" our star is selected for us whether or not we like it. Both of these may signify efficiency but many times efficiency is given a higher rating than freedom.

We are all benefited in some manner by many of the social reforms in our present social revolution. We are all taxed to pay for them. The higher our taxes the less freedom we possess to allocate the expenditure of our own personal incomes. The benefits we derive do not always justify this loss of freedom.

We like our Democracy because we have freedom. We know it is inefficient because in times of crisis we voluntarily place ourselves under a military dictatorship. When the crisis is over we prefer to make our own decisions even though we make many mistakes.

A physician on a salary as compensation is unquestionably efficient and practical. Witness the high type of medical service rendered our medically indigent through the Government Physicians under the direction of the Board of Health. Witness the medical care given our plantation employees under the physicians appointed by the plantation managers—the best medical service offered any agricultural group in the world! It is efficient and also practical because an abrupt change to free choice of physician would involve economic hazards which might be crippling.

Certainly the lay person does not have sufficient medical background to choose the physician best qualified to treat all of his various ailments. But that freedom to choose his own doctor nurtures dignity and is the basic principle of Democracy.

Perhaps the time is ripe to appoint a committee of doctors in the Territorial Association to study medical industrial relations. The interest of the Profession in Industry's problems alone might create good will.

Free choice of physician may not be practical at present but indeed it is a noble aim. The star may be far away but we can shape our course in its direction.



Hawaii
MEDICAL JOURNAL
OFFICIAL PUBLICATION OF THE HAWAII TERRITORIAL MEDICAL ASSOCIATION

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# [EDITORIALS]

## HOSPITAL COSTS BEING STUDIED

A two-year, half-million dollar study of hospital costs has been begun by the independent, 34-member Commission on Financing of Hospital Care, under the chairmanship of President Gordon Gray of the University of North Carolina. Jointly sponsored at the outset by the American Hospital Association and the American Medical Association, this remarkable Commission includes such well-known figures as Dr. George Baehr, Paul Hawley and Morris Fishbein, and, on the Technical Advisory Committee, one of Marjorie Shearon's nemeses, George St. J. Perrott, Chief of the Division of Public Health Methods in the U.S.P.H.S. Funds for the study are being provided by six foundations and an insurance company.

Directing the study itself is Graham Davis, who has been granted a two-year leave of absence from his position as director of hospitals for the Kellogg Foundation. Associate Director is Harry Becker, formerly social security director for the UAW-CIO. Medical Director is Dr. Donald Caseley, medical director of the University of Indiana Medical Center.

Highlights of the Commission's planned investigation are an evaluation of hospitals' current financial position and the need and demand for their services; evaluation of systems of payment for hospital care; analysis of the effect of methods of practice on hospital costs; and finally, recommendations for effecting such changes in financing of hospital care as the study may indicate. Financing of hospital care for non-wage [indigent?], low income, rural and chronic illness groups will also engage the Commission's particular attention.

Ably staffed, amply financed, and sparked by representatives of private enterprise, this Commission should come up in 1954 with some useful and enlightening information on this most vexing problem.

## VOLUNTARY HEALTH INSURANCE CRITICIZED

A 1947 study of the medical expenses of 455 statistically representative middle-income ($3000-$4000) families in the San Francisco Bay area was published last December by the University of California's Heller Committee for Research in Social Economics. Medical costs incurred by one-fourth of these families were over 10 per cent—and in one-fourth of this fourth, over 20 per cent—of their annual income.

Curiously, only one-fourth of the medical care recipients who were members of some type of insurance plan received benefits through the plan, and in many of these instances it was said to have been inadequate. The author of the study concluded, in fact, that voluntary health insurance had been "tried and found wanting."

A professor of social science at the University of London, writing in a recent issue of the *Lancet,* cites the report in detail as evidence that the American health insurance program is a failure and that the N.H.S. should not be criticized for having delivered so disappointingly little in the way of preventive medicine.

This seems a pretty broad conclusion, considering that the study is nearly 5 years old now and was based on only 455 families. Still, California Physicians' Service has been in business a long while, and presumably does its job as well as any voluntary health insurance agency and better than

most. A criticism of it is a criticism of all our plans. If the committee's findings and conclusions weren't sound, what was wrong with them? It seems that at least a critique of this study—if not a repetition of it—is most decidedly in order. The unadorned assertion that voluntary health insurance is the American Way isn't enough. Let's have some information, please!

## AN APOLOGY

The HAWAII MEDICAL JOURNAL for July-August, 1951 contained an article entitled "The Effect of Penicillin Upon Bacteremia Following Tooth Extraction" by Robert Joseph Fanning, D.D.S., who was then a captain in the Dental Corps, U.S.A., stationed at Tripler Army Hospital. It was submitted to us as an original study and we published it in good faith as is our usual custom with manuscripts submitted to us.

It has been brought to our attention very recently by I. B. Bender, D.D.S., of Philadelphia, co-author with Robert S. Pressman, M.D., of an article "Effect of Sulfonamide Compounds on Transient Bacteremia Following Extraction of Teeth," published in the *Archives of Internal Medicine*, November, 1944, that Dr. Fanning's article was similar in so many respects to theirs that it could not be considered a coincidence.

Our Editorial Board has compared the two articles and is in full accord with Dr. Bender, to whom we offer our sincere apologies for unwittingly being a part of this. Dr. Fanning was promptly contacted and admitted that being inexperienced he had "used Dr. Bender's article as a guide and did use his method of presentation and his type of tables." Due credit was not given to the original authors and Dr. Fanning said that "the references that were omitted are purely my fault."

Apparently Dr. Fanning's grave error was committed, as he says, with "no attempt to deceive or take credit for anything done by anyone else." In closing his letter to us, he said, "Again, my deepest regrets that your integrity should be questioned. My neglect or misunderstanding of using someone's work is my fault and should not in any way cast any mar on you and the Territorial Medical Association."

In the history of the HAWAII MEDICAL JOURNAL this is the first instance of this nature. We exceedingly regret its occurrence and wish to take this opportnnity to express that regret to Dr. Bender and Dr. Pressman.

This raises a question in the ethics of publishing which perhaps is not clear to all medical authors. According to "Medical Writing" by Morris Fishbein and "The Manuscript, A Guide for its Preparation" by John Wiley & Sons, Inc., a writer does not have the right to copy material from another author merely by giving credit in his article. A wise precaution, in order to avoid infringement of copyright, is to secure permission from the author and the publisher before taking excerpts from the work of another. Many authors may write on similar subjects, but the purpose of the copyright is to protect the language, creative thought and method of presentation of an author. Because medical literature is now so voluminous, no editor can be familiar with all material published in the medical and related scientific fields. It is therefore the primary responsibility of each author to comply with copyright laws and the ethics of medical writing relative to quotations and references.

# THIS IS WHAT'S NEW!

Mixed results in the treatment of **chronic active rheumatic fever** with **Cortisone** and **ACTH** are reported by Young and Rodstein (*Arch. Int. Med.* 90:60 [July] 1952). Symptomatic relief and clearing of refractory congestive failure occurred regularly, with definite remissions in 2 patients. However, the cause was not detectably shortened in the other 6 patients .

* * *

**Venous thrombosis** in a pregnant woman can be treated safely with **Dicumarol,** asserts Mansell (*Am. J. Obst. & Gyn.* 64:155 [July] 1952). Reviewing the literature and his own experience found a 15 per cent mortality in untreated cases and zero mortality in patients treated with Dicumarol. No harmful effects on fetus were uncountered.

* * *

**Folinic acid,** 1000 units I.M. daily produced prompt remission of **sprue** and satisfactory hematologic response in 6 patients; Romero et al., think folinic acid is 10 to 15 times more potent than folic acid, on a weight basis. (*Am. J. Med. Sci.* 224:9 [July] 1952).

* * *

**Prodigiosin,** a purple dye extracted from cultures of Bacillus Prodigiosus (Serratia marcescens), seemed to have a definite beneficial effect in 6 of 9 cases of **disseminated coccidioidomycosis.** The drug is difficult to prepare and difficult to administer, but holds promise in a heretofore hopeless disease. (Wier, et al., *Am. J. Med. Sci.* 224:70 [July] 1952).

* * *

**Nonspecific urethritis** was cured in 40 of 50 patients treated with **Terramycin** by Willcox and Findlay (*Am. J. Syph. Gon. and Ven. Dis.* 36:388 [July] 1952). Others believe that guava juice and gentle music would also cure 80 per cent of such patients.

**Intravenous iron** in **resistant hypochromic anemias** is apparently safe in pediatric practice, too. Dickstein, et al. report a dependable and rapid rise in hemoglobin in 80 infants and children treated with intravenous iron (*Am. J. Dis. Child.* 84:52 [July] 1952). Reactions are not more frequent, and are less severe than with blood transfusions. To say nothing of the difference in cost.

* * *

Penn reports remarkable control of **post-tonsillectomy pain** for 5 to 6 days by one injection of **"Efocaine"** into the anterior and posterior pillars at the conclusion of the operation. Pharmacologic studies had earlier demonstrated that anesthesia lasting more than a week was produced by this agent, which crystallizes out of solution upon injection into tissues. (*Arch. Otolaryngol.* 56:59 [July] 1952).

* * *

**Actidione,** extracted from cultures of Streptomyces griseus (the organism which produces Streptomycin) is perhaps the only drug of any value in the treatment of **C N S cryptococcosis** (Torula histolytica meningitis). (Carton, *Ann. Int. Med.* 37:123 [July] 1952.

* * *

A great rarity, recovery in a patient with **fulminant hepatitis** who had lapsed into coma, is reported by Ducci and Katz (*Gastroenterol.* 21:357 [July] 1952). Such miracles occurred in 2 patients after treatment with high doses of **cortisone** plus **aureomycin** and/or **terramycin.**

* * *

The Ann Arbor group has shown that adding **caffeine** and **phenacetin** to an **antihistamine** pill does not improve results obtained with the antihistamine alone in the treatment of **hay fever.** (Johnson, et al. *J. Allergy* 23:365 [July] 1952).

C. A. Domzalski, Jr., M.D.

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## Recent Acquisitions

**Anatomy and Physiology**

Ferrer, M. J. *Cold injury.* Transactions of the first conference, June 4-5, 1951. c1952. (gift of Josiah Macy, Jr. Foundation).

Francis, C. C. *The human pelvis.* c1952. (gift of publisher).

Grant, J. C. B. *A method of anatomy.* 3rd ed. c1944. (gift of Dr. Brown).

**Biography and History**

Larsell, O. *The doctor in Oregon.* c1947. (gift of Dr. Brown).

Williams, Harvey. *Doctors differ.* c1952. (gift of publisher).

**Clinical Medicine**

Cutting, W. C., ed. *Annual review of medicine.* v.3. 1952.

Piersol, A. M., ed. *The cyclopedia of medicine, surgery and specialties.* c1951. (gift of Dr. Nishijima).

**Dermatology**

Behrman, H. T. *The scalp in health and disease.* c1952. (gift of publisher).

**Endocrinology**

Greenblatt, R. B. *Office endocrinology.* 4th ed. c1952. (gift of publisher).

Selye, Hans. *The story of the adaptation syndrome.* c1952. (gift of publisher).

**Hematology**

Andresen, P. H. *The human blood groups.* c1952. (gift of publisher).

Mollison, P. L. *Blood transfusion in clinical medicine.* 1951. (gift of publisher).

**Kidney**

Farr, L. E. *Treatment of the nephrotic syndrome.* c1951. (gift of publisher).

**Ophthalmology**

Beach, S. J. *Principles of refraction.* c1952. (gift of publisher).

**Parasitology**

Belding, D. L. *Textbook of clinical parasitology.* 2nd ed. c1952. (gift of publisher).

**Pharmacology and Therapeutics**

Davis, J. E. *Clinical applications of recreational therapy.* c1952. (gift of publisher).

Florey, Sir Howard. *Antibiotics.* 1951. (gift of publisher).

Kremers, Edward. *History of pharmacy.* 2nd ed. rev. & enl. c1951. (gift of Dr. Nishijima).

Riviere, Maya. *Rehabilitation of the handicapped: a bibliography, 1940-1946.* 2 v. c1949. (gift of W. K. Kellogg Foundation).

**Psychiatry**

American Psychiatric Association. *Diagnostic and statistical manual—Mental Disorders.* c1952. (gift of publisher).

Campbell, J. D. *Everyday psychiatry.* 2nd ed. c1949. (gift of Dr. Nishijima).

Overholser, Winifred. *Handbook of psychiatry.* c1947. (gift of Dr. Nishijima).

Saul, L. J. *Emotional maturity.* c1947. (gift of Dr. Nishijima).

**Roentgenology**

Buschke, Franz. *Supervoltage roentgen therapy.* c1950. (gift of Dr. Nishijima).

**Surgery**

Beecher, H. K. *Principles, problems and practices of anesthesia for thoracic surgery.* 1952. (gift of publisher).

Callander, C. L. *Surgical anatomy.* 2nd ed. rev. c1948. (gift of Dr. Nishijima).

Maingot, Rodney, ed. *Techniques in British surgery.* c1950. (gift of publisher).

Maltz, Maxwell. *Evolution of plastic surgery.* c1946. (gift of Dr. Nishijima).

**Tumors**

Ward, G. E. *Diagnosis and treatment of tumors of the head and neck.* c1950.

* * *

The Library wishes to acknowledge with thanks an Endowment Fund contribution of $100.00 from Dr. Felix.

At a recent meeting of the Library Committee the matter of contributions to the Fund was discussed, and Dr. Felix learned that he was one of the several Medical Society members who had not contributed in 1944, at the time of the Fund's inception. Many of the present members of the Medical Society were in military service at that time, and away from the Islands. Others who have joined the Society since 1944 perhaps are unfamiliar with the financial organization of the Library.

The original plan of the Endowment Fund was that eventually its earnings would contribute materially to the support of the Library, thus relieving the Medical Society of a great portion of that burden. Moreover, it was intended as a safeguard in the event of emergencies or curtailment of other income. The Library was therefore incorporated as an eleemosynary institution, and donations to the Fund were exempt from taxation.

If any member of the Society is in doubt as to whether or not his name appears on the list of non-contributing members, he can inquire at the Library. Needless to say, any contributions will be gratefully received.

# BOOK REVIEWS

### The Story of the Adaptation Syndrome.

By Hans Selye, M.D., Ph.D., D.Sc., F.R.S. (C.), 225 pp., Price $4.50, Acta Inc., 1952.

Handsomely bound in limp red leather, with round-cut page-corners, and beautifully printed, this volume of informal lectures is an excellent introduction to the General Adaptation Syndrome and its aberrations. Dr. Selye takes the subject up in narrative form, from his first intimations of the Stress Hypothesis when he was an undergraduate in Prague, through the early experiments and disappointments, up to the development of the theory in its present—still incomplete—form.

The book is perfectly suited for those who are disinclined to plow through the much thicker volumes with their thousands of references. So informal and clear is its style that it would be informative even to the educated layman. It is unreservedly recommended for every physician.

HARRY L. ARNOLD, JR., M.D.

### Child Psychiatric Techniques.

By Lauretta Bender, B.S., M.A., M.D., 360 pp. with 74 illustrations, Price $8.50, Charles C. Thomas, 1952.

Beginning with a survey of the status of child psychiatry today, this book presents a wealth of material regarding the study of the problems of personality development in children.

Wide in scope, many approaches in the diagnostic study, psychodynamics, and treatment of children are discussed. Considerable emphasis is placed on the visual motor Gestalt and artistic expressiveness, and the value of group activities, clay modeling, puppet shows, and dancing is also discussed.

Because of the technical nature of large parts of the book, it is likely that interest in it will be largely limited to those directly working with the emotional problems of children. For these, the book is a valuable contribution, for Dr. Bender is able to draw material from a wide clinical experience in her work at the children's service of the psychiatric division of Bellevue Hospital in New York City.

KENNETH H. RUSCH, M.D.

### The Present Status of Antibiotic Therapy with Particular Reference to Chloramphenicol, Aureomycin, and Terramycin.

By Francis G. Blake, M.D., 26 pp., Price $.90, Charles C. Thomas, 1952.

The content of this short publication was delivered to a group of laboratory workers in the summer of 1951. The booklet presents succinctly the status of the therapeutic agents, chloramphenicol, aureomycin, and terramycin, and indicates the special virtues of each of them. It will serve as a review for the physician but will be of particular value to nurses, laboratory workers, and other workers in the field of medicine.

SAMUEL D. ALLISON, M.D.

### Refraction and Motility.

By Walter B. Lancaster, M.D., 342 pp. with 106 illustrations, Price $7.75, Charles C. Thomas, 1952.

This text is written in a manner that makes it very easy to read. It is different from other text books on refraction in that the mathematical formulas are left out. The portion of the text on refraction is full of Lancaster's personal views which are more practical than theoretical. For one who desires a complete practical knowledge of the subject without wading through a great deal of technical detail, this book is highly recommended.

WAYNE W. WONG, M.D.

### The Human Blood Group.

By P. H. Andresen, M.D., 124 pp. with 19 tables, Price $3.75, Charles C. Thomas, 1952.

This is a short and concise book which presents the basic facts now established relative to blood groups and their importance in disputed paternity cases and criminal proceedings. The book jacket states that "No Biology Background (is) Required To Understand This Book." That may be so, but possibly we should have it reviewed by an individual meeting these requirements. I do not mean to imply that the book is too difficult to understand, yet by its very omissions and elimination of details I fear that wrong interpretations may result to the uninitiated by its very simplicity.

It would be preferable to consider this monograph as an introduction to a very complex and unsettled problem. Nevertheless, the book is recommended for reading and study to both physicians and lawyers interested in this subject.

LEON E. MERMOD, M.D.

### Anesthesia for Thoracic Surgery.

By Henry K. Beecher, M.D., 65 pp., Price $2.50, Charles C. Thomas, 1952.

This monograph should prove of value and interest to surgeons and anesthesiologists alike. The author has successfully avoided discussion of highly debatable subjects in anesthesia technic and based his recommended procedures and precautions on the altered physiology encountered in patients with pulmonary or circulatory disease and those on whom thoracotomy is performed. The problems encountered in thoracic surgery are clearly if briefly expounded. Prophylaxis and treatment of untoward disturbances in physiology are described as dealt with in the author's Department of Anesthesia, Massachusetts General Hospital. Anesthetic agents and methods of administration recommended are those that could be adopted by any hospital department of anesthesia without highly specialized equipment. An increased understanding of the problems of the anesthetist by the surgeon and of the surgeon's problems by the anesthetist should aid in the services rendered each other and the patient.

CARL E. JOHNSEN, JR., M.D.

### Early Care of the Seriously Wounded Man.

By Henry K. Beecher, M.D., 32 pp., Price $.75, Charles C. Thomas, 1952.

This small pamphlet contains much valuable information which is quickly stated without any unnecessary words. Each sentence is informative. Much of the contents is well known but this tiny booklet should serve as a reference book for those in teaching and those organizing medical planning for disasters.

The section dealing with the administration of intravenous sodium pentothal could be read with profit by everyone doing surgery. Its indications and contraindications are clearly stated. This reviewer believes that this drug is given too often to patients who have not been given proper premedication and often to patients where another anesthetic agent would be a wiser choice. We are lulled into a false sense of security because "we get away with it." The study of this section of this pamphlet by all physicians might prevent unnecessary danger to our patients.

DEAN M. WALKER, M.D.

### Doctors Differ.

By Harley Williams, 253 pp. with 8 illustrations, Price $5.50, Charles C. Thomas, 1952.

Medical editors, orthopedic surgeons, psychiatrists, neurosurgeons, cardiologists and phthisiologists will find especially fascinating reading in this little volume of biographical essays on contrasting figures in (principally) British medical history. No doctor, however, could fail to find them well worth reading. The general pattern in the book is a series of contrasts between physicians of comparable eminence, in each of the above fields.

One gets the impression that the author is a layman. A curious phrase is *"Tubercle Bacillus,* generally shortened to T.B.," whereas actually, in the U.S. at least (but perhaps not in the U.K.?), "T.B." is a contraction of "TuBerculosis." On page 203, René Théophile Hyacinthe Laënnec is miscalled René Théo*dore* Hyacinthe Laennec. But the slips are few and unimportant. The book is highly recommended for information, entertainment, and inspiration.

HARRY L. ARNOLD, JR., M.D.

### Blood Transfusion in Clinical Medicine.

By P. L. Mollison, M.D., M.R.C.P., M.R.C.S., 456 pp., Price $8.00, Charles C. Thomas, 1952.

The use of blood transfusions in the medical armamentarium has increased immeasurably during the past few years As a corollary, new books on transfusions appear every few months. It is refreshing, indeed, to review a book in which is assembled all the knowledge accumulated on this subject by one well-informed man. Dr. Mollison, with the help of his co-workers, his practical experience and his meticulous research is able to discuss all aspects of transfusions from the laboratory as well as from the practical standpoint.

It is my belief that Mollison's book, with occasional revisions, will be the transfusionist's reference text for a long time to come. It should not be necessary, therefore, to advise every physician, whether he gives one or a hundred transfusions a year, to read, study, and refer to this practical monograph. Mollison's "Transfusion" wastes no one's time.

LEON E. MERMOD, M.D.

### Antibiotics.

By Sir Howard Florey, F.R.S., M.S., Ph.D., 35 pp., Price $1.50, Charles C. Thomas, 1952.

This monograph is the fifty-second Robert Boyle Lecture delivered before the Oxford University Scientific Club on June 1, 1951 by Professor Sir Howard Florey of the Sir William Dunn School of Pathology, Oxford, England. The lecture is a simple discussion on antibiotics (antimicrobials) including source, manufacture, testing, scope and possibilities, presenting in a simplified manner various technical aspects of the "wonder drugs." It is published as a short monograph for light scientific reading and is recommended for anyone who would like to get a general introduction into antibiosis. This monograph can conceivably be of interest to practitioners in all fields of scientific endeavor.

W. HAROLD CIVIN, M.D.

### Textbook of Clinical Parasitology.

By David L. Belding, M.D., Second Edition, 1139 pp., Price $12.00, Appleton-Century-Crofts, Inc., 1952.

The second edition of Belding's Parasitology is some 250 pages longer than the first edition. The added material deals with the increased knowledge of parasitology gained during the war; also the newer drugs and methods of treatment are emphasized. Diagrammatic outlines are used to good advantage in describing the life cycles and characteristics of the parasites.

The book is written primarily for medical students, laboratory personnel, and physicians dealing with parasitology, such as public health officials; but it is also of value to the practicing physician in its complete coverage and treatment of the common parasites that infest man.

ETTA WRIGHT BEST, M.D.

### Living Agents of Diseases.

By James T. Culbertson and M. Cordelia Cowan, 624 pp., illustrated, Price $5.50, G. P. Putnam's Son, 1952.

This book quite successfully covers the broad field of pathogens and their relation to the individual and society as a whole. Each discussion is necessarily terse and is primarily written for students interested in health programs, rather than for physicians.

There are a few statements or tables that might be criticized. On page 36, under "Mortality Rates for Infectious Diseases in the United States," lymphogranulomatosis is fifth in incidence. This is because, in the old classification, Hodgkin's disease is classified under "Other Infectious Agents." Since 1949, it is included in the neoplasms.

The statement on page 297, "The principal human diseases with which the rat is identified are bubonic plague and epidemic typhus fever," is incorrect. Also on page 311, the statement, "None of the viruses has yet been shown to be susceptible to chemotherapy," is open to question. This may be due to the use of Bergey's classification of lymphopathia venereum, primarily atypical pneumonia, trachoma and psittacosis under Chlamydozoaceae rather than true viruses.

This book can be recommended to teachers and students of health problems as well as nurses. Physicians preparing teaching courses in infectious diseases and their causes will find it useful. Chapter 39, concerning facilities and personnel for the control and eradication of infectious diseases, and Chapter 40, concerning laws relating to these diseases, are particularly valuable.

JAMES R. ENRIGHT, M.D.

### Congenital Dysplasia of the Hip Joint and Sequelae.

By Vernon L. Hart, M.D., F.A.C.S., 216 pp. with 136 illustrations, Price $5.00, Charles C. Thomas, 1952.

The author does a good job with this subject. The book is well illustrated and to the point. He points out clearly the early clinical findings that are often noted by mothers. They are: (1) limitation of passive abduction in the involved hip when changing diapers, (2) the infant does not move the involved extremity freely, and (3) the baby powder remains in one unusually deep skin crease.

However on treatment, it is unfortunate that the author goes overboard and confines his entire discussion to the use of the Freijka splint. This certainly is not the only way to treat congenital dislocated hips. The theory back of the Freijka splint is that it provides active and functional immobilization.

This book is easy to read and well produced. The x-rays and photographs are above the average in quality. It should be of interest to those who are regularly called upon to deal with congenital dislocated hips.

B. Allen Richardson, M.D.

### Clinical Applications of Recreational Therapy.

By John Eisele Davis, M.S., Sc.D., 126 pp. with 21 illustrations, Price $3.75, Charles C. Thomas, 1952.

As the author states in his foreword, "There is no attempt in this monograph to discuss society's responsibility for recreation, or the mechanics necessary for setting up the recreational plant and staff. The aim has been to discuss the concepts of recreation in its relationships to mental health, to explore some of the recent developments in medical science and method in which specific utilization of physical exercise and activities becomes a most important dynamic component of treatment."

This is a concise, well organized, complete, theoretical presentation of the principles of recreational therapy. The specific discussions of all types of patients, and activities suitable in their rehabilitation, are well put and of practical value to occupational therapists who of necessity must carry on recreational activities. The charts are well organized and definitely helpful in the observation and grading of patients.

Geraldine Y. K. Tom, OTR

### The Human Pelvis.

By Carl C. Francis, A.B., M.D., 210 pp., Price $5.00, C. V. Mosby Company, 1952.

This monograph encompasses the field of descriptive anatomy of the human pelvis, both male and female. No clinical interpretations or applications are presented. The subject matter is presented clearly and concisely with excellent text and illustrations. The paper, binding and printing are good.

As a reference work on pelvic anatomy this monograph is a worth-while addition to our library.

Frank C. Spencer, M.D.

### Synopsis of Genitourinary Diseases.

By Austin I. Dodson, M.D. and Donald L. Gilbert, M.D., Fifth Edition, 313 pp., 122 illustrations, Price $4.00, C. V. Mosby Company, 1952.

The book is a brief synopsis of the major genitourinary diseases, evidently written primarily for medical students. It is devoted largely to etiology, pathology and diagnosis and contains no technics of treatment.

There is an excellent chapter on impotence and sterility with sound, sensible remarks regarding etiology and treatment.

The chapter on urinary calculi is also excellent. There is an elaborate discussion of the etiological factors of the stone formation and good sound advice regarding the handling of this vexatious condition. The book is well written, clear and concise.

P. S. Irwin, M.D.

## Also Received

### Clot Retraction.

By O. E. Budtz-Olsen, M.D., 149 pp., Price $5.50, Charles C. Thomas, 1952.

### Mind Perception and Science.

By W. Russell Brain, D.M., F.R.C.P., 90 pp., Price $2.50, Charles C. Thomas, 1952.

### Handwriting.

By Frank Victor, Ph.D., 168 pp. with 22 illustrations, Price $3.75, Charles C. Thomas, 1952.

### Bacitracin.

127 pp., S. B. Penick & Company, 1952.

### Studies on Testis and Ovary Eggs and Sperm.

Edited by Earl T. Engle, 256 pp. with 95 illustrations, Price $7.50, Charles C. Thomas, 1952.

### Working Programs in Mental Hospitals.

Edited by Daniel Blain, M.D. (Proceedings of the Third Mental Hospital Institute), 203 pp., Price $2.50, American Psychiatric Association, 1952.

### Diagnostic and Statistical Manual—Mental Disorders.

Prepared by the Committee on Nomenclature and Statistics of the American Psychiatric Association, 130 pp., American Psychiatric Association, 1952.

### Medical Clinics of North America.

May 1952, New York Number, pp. 601-907, illustrated, $18.00 per clinic year cloth binding, $15.00 per clinic year paper binding, W. B. Saunders Company, 1952.

### Transactions of the American Ophthalmological Society, 1951.

Vol. XLIX, 728 pp., illustrated, price $15.00, Columbia University Press, 1952.

### The Surgical Clinics of North America.

April, 1952, New York Number, pp. 345-693, figs. 141-193, $18 per clinic year, cloth binding, $15 per clinic year, paper binding, W. B. Saunders, 1952.

### The Surgical Clinics of North America.

June, 1952, Lahey Clinic Number, pp. 695-979, figs. 194-299, $18 per clinic year, cloth binding, $15 per clinic year, paper binding, W. B. Saunders, 1952.

### The Medical Clinics of North America.

July, 1952, Los Angeles Number, pp. 909-1200, figs. 74-119, $18 per clinic year, cloth binding, $15 per clinic year, paper binding, W. B. Saunders, 1952.

### A Student's Radiological Mathematics.

By L. A. W. Kemp, B.SC., F.INST.P., 315 pp., Price $5.00, Charles C. Thomas, 1952.

# HMSA—Its Place in the Community

## Enrollment and Membership Service

J. R. VELTMANN, *General Manager*

HMSA is known as Hawaii's voluntary prepayment plan providing the best possible medical, surgical and hospital care for the general public, but how does HMSA go about offering its services in the community?

HMSA coverage is available to any employed person through his place of employment. An employment unit of five or more persons constitutes a group and is entitled to group coverage. Protection for dependents is available to any group where at least 50 per cent of the married employees include their dependents for coverage. Dependents are confined to immediate family only, spouse under age 65 and children between the ages of 1 and 19 years.

A prospective group has a choice of three basic plans, and may have any plan explained by writing to the nearest HMSA office. A Sales and Service Representative is always available to call on a prospective group to conduct group talks or personal consultation relative to any of our plans. Group talks are designed to outline all benefits of the certificate and to acquaint the prospective members with the general functions of the plan.

While HMSA is basically a group plan, individual enrollment is offered to the public from time to time for those who do not qualify under group requirements. Self employed persons are permitted to enroll twice a year and may be covered for Surgical-Hospital or Hospital Care. Through the above means, HMSA protection is available to the entire community.

HMSA Enrollment and Membership service is under the supervision of Sales and Service Supervisors on the Islands of Oahu, Hawaii, Maui and Kauai. These district managers arrange for bi-annual servicing of each established group. A representative calls on each group every six months to review problems; to sign up members who failed to enroll when the plan first became available, and to coordinate HMSA activities with designated group leaders.

As an additional service to the membership, HMSA maintains a Retention Program. Under this program a member who leaves an employed group is privileged to continue on an individual basis under our surgical-hospital plan or the hospital plan. Upon notification of termination of employment by the group, contact through mail or telephone is made to the member offering continued membership, and the member is allowed sufficient time to effect a transfer from a group to a Bill Direct basis. "Bill Direct" members are mailed payment notices at their residence on a bi-monthly basis, and are allowed a thirty day grace period from "Due Date" to pay the dues. HMSA works diligently to properly service all its members in an effort to keep them medically protected.

Leading business firms in the Territory of Hawaii have incorporated HMSA protection in their industrial relations programs, and contribute substantially toward the welfare and health protection of their employees and their families. Following is a table showing the number of groups where the Company participates in the HMSA program:

| COMPANIES CONTRIBUTING FOR: | NUMBER OF COMPANIES | % OF HMSA DUES PAID BY EMPLOYER |
|---|---|---|
| Employee and Family | 22 | 100% |
| " " " | 2 | 75% |
| " " " | 33 | 50% |
| " " " | 1 | 40% |
| Subscriber | 84 | 100% |
| " | 1 | 75% |
| " | 83 | 50% |

This represents thousands of members where the welfare of employees and their families are considered important by employers. HMSA is grateful to have been selected as the agency to offer good health protection.

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Hawaii County Medical Society was held at the Staff Room of the Hilo Memorial Hospital at 7:30 p.m., June 26, 1952, with President S. Kasamoto, presiding. There were 19 members present. Guests: Messrs. L. Rowland, Veltmann, and Dr. R. Faus.

The Hawaii County Medical Society endorsed participation in the Health Council on motion by Dr. T. D. Woo, seconded by Dr. N. Steuermann.

The subject of rehiring a medical librarian for the Hawaii County Medical Society Library was discussed. However, until further report from the Library Committee could be made, no steps were taken. It was also suggested that the library obtain some aid from the Managing Committee.

Mr. L. D. Rowland spoke on the subject matter of "Rehabilitation of Chronic Patients."

"The HMSA" was the topic of Mr. J. Veltmann's talk. The Medical Society was informed of the difficulties encountered by the HMSA, especially on the island of Hawaii.

The meeting adjourned at 10:45 p.m.

* * *

The 322nd regular meeting of the Hawaii County Medical Society was called to order by President S. Kasamoto at the Naniloa Hotel at 7:45 p.m., Thursday, July 26, 1952. Members present were: Drs. Bergin, Crawford, Higa, Kasamoto, Matsumura, Okumoto, Orenstein, Ota, Oto, Steuermann, Woo, Yamanoha, and Yuen. Guest: Dr. Vasconcellos of Honolulu.

The Society approved of the Hawaii Heart Association's request to conduct another cardiac clinic soon.

A letter was received from Dr. Richard Lee of the Board of Health, Honolulu, regarding the reconversion plan for radium supply in the territory. At present the local Board of Health has a supply as follows:

9—10 mgm. radium tubes
1—25 mgm. radium tube
1—10 mgm. radium needle
5— 5 mgm. radium needles

Dr. H. E. Crawford made the motion that this county should suggest to the Territorial Association that we be allowed to retain our present supply until further studies can be made both by the territory and all the counties alike. It was pointed out that the late Dr. Howes of the Hilo Memorial Hospital strongly favored the usage of smaller dosage of radium like those we have at hand.

A letter from the HMSA office dated July 23 was read. The secretary was directed to inform the HMSA that the rest of the 10% Physicians' Reserve be reimbursed since the association was operating on a territorial-individual basis. As of March 24, 1952, "the reserve fund of 1% has been considered on a county basis rather than territorial."

A letter from the Postgraduate Committee of the Hawaii Territorial Medical Association was read. To participate in such postgraduate program, a seminar group was selected with Drs. Yuen (Chairman), Orenstein, Matsumura, and Oto.

The semi-annual financial report was read by the Treasurer. To date there is a balance of $1,731.64.

The rest of the evening was turned over to Dr. Vasconcellos of Honolulu, who was introduced by Dr. Bergin. The speaker gave a brief history of the American Academy of General Practice. He also spoke about the future plans for postgraduate education in the islands. Discussion followed.

The meeting adjourned at 10:56 p.m.

RICHARD A. YAMANOHA, M.D.
*Secretary*

## MAUI COUNTY MEDICAL SOCIETY

A regular business meeting of the Maui County Medical Society was held at the Maui Grand Hotel on June 10, 1952, at 8:00 p.m. Vice-President Harold Kushi presided.

Members present: Drs. Izumi, Rockett, Toney, Cole, Kanda, McArthur and Underwood.

Visitors present: Dr. Robert Faus, Mr. Veltmann and Mrs. James.

Dr. Toney gave his delegate's report.

Dr. McArthur discussed the possibility of having a definite amount of money at the disposal of the Program Committee to be used to defray the expenses of visiting lecturers, this fact to be made known to the other County societies and the Territorial Association so they can start a similar fund and make it easier to route visiting lecturers to the outside islands. Moved by Dr. Cole, seconded by Dr. Toney, that the sum of $200.00 be set aside for this purpose.

Dr. Toney was elected by the Society to the Board of Governors of the Hawaii Medical Service Association, vice Dr. Lathrop. The change is necessary because of a rule of HMSA that members must be in general practice. The secretary is to inform Dr. Lathrop, in writing, of the change.

Mr. Veltmann gave a report on the present status of HMSA and brought out the following facts and statistics:

a) 100 per cent of Maui doctors participate and 96 per cent of all the practicing doctors in the Territory participate. This percentage will be improved further within the next week.
b) $62,000 was placed in the contingency fund in 1951. There was a deficit of $44,000 in 1950.
c) Subscribers were paid back $.813 for each dollar invested.
d) Maui County showed a profit of $5,000 which would have been $12,000 if one less visit was made for each illness.
e) HMSA is going to send a representative to Maui in the near future to instruct doctors and hospitals' secretaries in the proper way to make out forms.
f) All "gripes" by patients are to be referred to Mrs. James.
g) For the next month there will be an open period when individuals may join HMSA. This plan will not include office and house calls.
h) The Permanente Plan was explained. In addition to regular dues, members pay $1.00 per office call, $2.00 per house call, $35.00 for child's tonsillectomy, $50.00 for adult's and $95.00 for delivery.

Dr. Faus thanked the doctors for their cooperation in supporting the plan and assured them that he would look out for their interests.

Dr. Burden's committee appointments for the ensuing year are as follows:

*Program Committee:* Dr. Patterson, chairman; Dr. McArthur, Dr. Rockett
*Publicity:* Dr. Tompkins, Dr. Ohata
*Cancer Committee:* Dr. Cole, chairman; Dr. Ferkany, Dr. Wong (To work with and advise the Cancer Society. At least one member to meet with the Cancer Society at their meetings.)
*Blood Bank:* Dr. Wong, chairman; Dr. Toney, Dr. Tompkins, Dr. St. Sure (To work with any organization sponsoring a blood bank drive.)
*Medical Economics and Public Relations:* Dr. McArthur, chairman; Dr. Sanders, Dr. Fleming
*Pathologist Committee:* Dr. St. Sure, chairman; Dr. Wong, Dr. Toney, Dr. Tompkins
*Territorial Medical Meeting:* Dr. Tompkins, chairman; Dr. Burden, Dr. H. Kushi, Dr. McArthur
*First Aid for Fair:* Dr. Underwood
*First Aid for Fourth of July:* Dr. Ohata
*Nominating Committee:* Dr. Shimokawa, chairman; Dr. Cole, Dr. Kanda
*Grievance Committee:* Dr. Harold Kushi, chairman; Dr. Lathrop, Dr. Ohata
*Advisor to Medical Auxiliary:* Dr. Izumi, Dr. McArthur
*Medical Disaster Committee:* Dr. Underwood, chairman; Dr. Ed Kushi, Dr. Shimokawa, Dr. Ferkany, Dr. Patterson, Dr. Rockett, Dr. Mar, Dr. Wilkinson, Dr. Reppun
*Golf Committee:* Dr. Ohata, chairman; Dr. Patterson, Dr. Rockett, Dr. H. Kushi
*Military Procurement and Assignment:* Dr. Underwood, chairman; Dr. Cole, Dr. Rockett, Dr. Burden, Dr. Haywood, Dr. Tofukuji, Dr. Kanda

Edmund Tompkins, M.D.
*Secretary-Treasurer*

## HONOLULU COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Society was held on June 6, 1952 at 7:30 p.m. in the Mabel Smyth Auditorium. Dr. Wm. M. Walsh presided with approximately 50 members and guests present.

Mr. Joseph Veltmann informed the Society that 99.6 per cent of the Society's membership have completed participating physicians agreements with the HMSA.

Dr. Samuel Allison, Chairman of the Public Service Committee, stated that the Public Opinion Poll of 1950 showed that one of the most common complaints of patients was the type of attention received from doctors' office personnel. It was felt that proper training of secretarial staffs would obviate these grievances. The Public Service Committee will inaugurate a three-hour course in the better handling of telephone calls designed to improve public relations. He further stated that Mutual Telephone Company offers this service at no cost to the recipient.

It was also announced that contributions to your medical school can now be made directly through the AMA Foundation and that the AMA will in turn transmit your donation with due credit to you, your class and your school. There will be no deduction for carrying charges.

A movie concerning "Malnutrition in the Hospital Patient" was viewed.

Dr. John Holmes discussed his experiences and medical observations in India. The Society was impressed with Dr. Holmes' colored slides which clearly depicted the contrasting beauty of the country with the intolerable living conditions of the masses.

On behalf of the Society, the Board of Governors welcomed Drs. Harry B. Allison, Richard Y. Chiang, William Nilssen, Jr. and Thomas K. Oshiro to regular membership. New associates are: Cols. Louis K. Mantell, Daniel J. Sheehan and Lawrence C. Ball, Major Paul F. Guerin, Capt. Ben David Hall, Lt. (jg) Phillip J. Moore and Lt. John P. Anderson.

C. M. Burgess, M.D.
*Secretary*

## KAUAI COUNTY MEDICAL SOCIETY

The regular meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital on Tuesday, July 8, 1952 at 7:30 p.m., presided over by Dr. Ishii in the absence of the president. Members present were Drs. Cockett, Boyden, Wallis, Goodhue, Wade, Kuhns, Masunaga, Ishii, and Kim. Guests were Dr. Faus, Mr. Veltmann and Mrs. Inouye from HMSA.

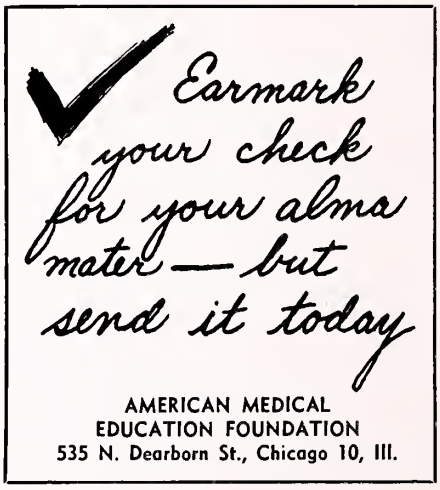
A letter from Mr. Veltmann of HMSA was read in which he requested the selection of an alternate director to attend meetings in the absence of the regular director, in accordance with a resolution adopted on May 23, 1952, amending the Constitution and By-Laws. Dr. Boyden was selected unanimously by the members.

Mr. Veltmann, General Manager of HMSA, then gave a very informative and encouraging report on the status of HMSA. He spoke on (1) conducting an office seminar to indoctrinate the office, hospital and medical personnel with HMSA policies; (2) the encouraging picture of the Physicians' Reserve Fund; (3) a suggestion that the financial statement be reviewed by the Society at every meeting and (4) the formula in handling non-participating physician claims.

Dr. Faus, Medical Director of HMSA, extended a few words of appreciation to the members of the Society for their continued confidence in the plan.

There being no further business, the meeting adjourned at 9:00 p.m.

Peter Kim, M.D.
*Secretary*

AMERICAN MEDICAL
EDUCATION FOUNDATION
535 N. Dearborn St., Chicago 10, Ill.

# NOTES AND NEWS

## MARCUS GUENSBERG, M.D.

### 1900-1952

On July 11, 1952, Hawaii suddenly and unexpectedly lost one of its most valuable citizens. Dr. Marcus Guensberg, late Medical Director of the Territorial Hospital, probably made a greater contribution to the mental health of the Territory than any other single person. Although his duties lay essentially with the Hospital itself, he gave endlessly of his time and effort to the community at large. He succeeded in taking an out-dated custodial institution and making of it a modern treatment center. At the same time, he helped greatly in disseminating the principles of emotional stability throughout the community. Such accomplishments were a natural expression of the personality of a kind and idealistic man with great intelligence and erudition at his disposal. Such assets, combined with the sympathy which is indispensable in a good physician, made him unusually capable in the utilization of psychiatric principles and technics and also served to inspire all people who knew him. He was a man of great vision and a forceful speaker.

Dr. Guensberg was born on June 17, 1900 in Gorlice, Austria. His higher education was at the University of Berlin, from which he received his M.D. in 1925. After his internship in Germany, he came to this country and began his psychiatric work at Manhattan State Hospital, New York. He spent several years in the practice of general medicine and pediatrics in both the United States and Mexico. He spoke both German and Spanish fluently. His interests always lay with the clinical and therapeutic side of psychiatry and he had great understanding of the problems of children. One of his hopes and plans was to establish a much needed treatment center for severely emotionally disturbed children in Hawaii.

He came to Hawaii in 1945 following three more years as a psychiatrist at Manhattan State Hospital. After a year as clinical director at the Territorial Hospital, he became medical director of the Hospital and remained in that position to the great benefit of the Hospital until his recent death.

He was psychiatric consultant to the Surgeon General and rendered much service to Tripler Army Hospital in Honolulu. He taught the graduate students of social work at the University of Hawaii. He was a very active member of the Mental Hygiene Society of Hawaii, as well as the Territorial Medical Association, the Honolulu County Medical Society, and the Society of Neurology and Psychiatry of Hawaii. Louise Guensberg, his wife, was born in Sweden and was a constant source of quiet, intelligent help and happiness to him. Dr. Guensberg was a lifelong Zionist and in fact bequeathed his personal library to the University of Israel.

The loss of Dr. Guensberg was a tremendous one to all of us; however, he left us with a rich heritage of both ideals and examples.

ROBERT A. KIMMICH, M.D.
*Clinical Director,*
*Territorial Hospital*

## PERSONALS

**Dr. R. O. Brown** left to attend the annual meeting of the American Urologic Association in Atlantic City. While away he will also visit the Mayo Clinic.

**Dr. Roy T. Tanoue** announces the opening of his office at the Medical Arts Building, with practice limited to surgery. Dr. Tanoue is a graduate of Rush Medical School in Chicago. He received his medical training at the Cook County Hospital in Chicago and was later awarded the Solomon Fellowship at the University of Chicago's Hektoen Institute. He is certified by the American Board of Surgery.

**Dr. Angie Connor** of the Territorial Department of Health resumed her duties as Chief of the Bureau of Maternal and Child Health and Crippled Children. During her year's absence from Honolulu, Dr. Connor received a Master's Degree in Public Health from the University of California at Berkeley.

**Dr. James R. Bobbitt** joined the Ear, Nose, and Throat Department of the Straub Clinic. Dr. Bobbitt is a graduate of the University of Southern California Medical School. He interned at the Los Angeles County Hospital and served his residency at the San Diego County Hospital and the V. A. Hospital in New Orleans. He is certified by the American Board of Otolaryngology. Dr. Bobbitt is married and has two children.

**Dr. Robert C. H. Chung** announces the opening of his office in general practice at 304 Kuulei Road, Kailua, Oahu. Dr. Chung is a graduate of the College of Medical Evangelists. He interned at the Los Angeles County Hospital and has just completed over two years service in the Army.

**Dr. Scott C. Brainard** returned to Honolulu to be associated with the Department of Surgery of the Medical Group. Dr. Brainard spent three years as a resident surgeon at Yale University Hospital, New Haven, Conn.

Also joining the Medical Group is **Dr. John R. Sedgwick, Jr.** Dr. Sedgwick is a graduate of the University of Pennsylvania Medical School and has recently completed his internship at The Queen's Hospital, Honolulu.

Arriving at Tripler Army Hospital to begin their

internships are twenty-one new Army and Air Force physicians who are graduates of mainland medical schools. They are: **Lourence I. Bonin,** Jefferson Medical College; **Horry E. Burkett,** Medical College of Georgia; **William D. Carter,** Iowa State; **Fronk E. Dudenhoffer,** University of Cincinnati; **Holcombe H. Hurt, Jr.,** University of Virginia; and **Robert C. McEligot,** State University Medical Center, Syracuse, New York.

Also here for duty are **Woyne S. Mercer,** Iowa State University; **Lowell J. Peck,** Iowa State; **Roger A. Simpson,** Iowa State; **Jock T. Todt,** Wayne University; and **Scott P. Wolloce,** University of Maryland.

Air Force Doctors are: **Michoel Curtis,** Tulane University; **Dover A. Dick,** University of Cincinnati; **Horry J. Holroyd, Jr.,** Western Reserve University; **Jomes K. Luce,** Yale Medical School; **Korl J. Olsen,** Ohio State University; and **Harold K. Tsuji,** Temple University. Other army doctors are **Robert E. Arendell,** Indiana University; **Charles E. Cook,** University of Arkansas; **Dana D. Cox,** University of Pittsburgh; and **Robert E. Rousseou,** Columbia University.

**Dr. Williom M. Wolsh** announces the association of **Dr. Cecil A. Sounders, Jr.,** general medicine and surgery, at Rm. 30, Young Hotel Building. Dr. Walsh recently left for the mainland for a short study trip.

**Dr. H. Q. Pong** announces the association of **Dr. Gordon H. Y. Chong** in general medicine and surgery at the Chock-Pang Clinic, 52 South Vineyard Street.

**Dr. Lester Koshiwo** returned to Honolulu after a year's residence in proctology at the Jefferson Medical School Hospital in Philadelphia.

**Dr. Corolino Dizon Wong** announces the opening of her office at 1638 Liliha Street for general practice. Dr. Wong is a graduate of Santo Tomas University in Manila. She served for several years at St. Francis Hospital and Kauikeolani Children's Hospital, Honolulu, as an intern and resident.

**Dr. W. John Holmes** and **Dr. Richard K. C. Lee** addressed the American Association for the United Nations. Dr. Holmes spoke on an eye caravan he conducted in the villages of India. Dr. Lee's subject was the program of the World Health Organization.

Licenses to practice medicine in the Territory of Hawaii were granted to Doctors: **Fugote Corty, Gordon Yen Hoy Chong, Eloine K. K. Chong, Doniel W. Kittredge, Jr., Williom Nilssen, Jr., John Richord Sedgwick, Jr., Eugene W. Swonsey,** and **Cecil Allen Saunders, Jr.**

**Dr. Robert Millord** left for an extended mainland study trip. In his absence, his practice is being covered by **Dr. Williom Nilssen, Jr.**

Back from mainland medical trips are: **Dr. Joseph E. Strode, Dr. John S. Lowrey, Dr. Lester Yee, Dr. Kozuo Miyomoto, Dr. Roymond C. Yop,** and **Dr. E. R. Austin.**

**Dr. Somuel Allison** left for Southeastern Asia on a United Nations Health Mission. He will spend two months in the Philippines, Formosa, Hong Kong, and Indo-China on programs of yaws and venereal disease control.

**Dr. Chorles Wilbor,** President of the Territorial Board of Health and also President of the State and Provincial Health Authorities of North America, returned from the annual meeting of the latter organization.

**Dr. Dorion Poskowitz** left for California where he was married. Upon his return, he will enter private practice in Aina Haina.

**Dr. Thomas K. Oshiro** announces the opening of his office in general practice at 1415 King-Kalakaua Building. Dr. Oshiro is a graduate of the Hawaiian Mission Academy, Union College at Lincoln, Nebraska, and the College of Medical Evangelists at Loma Linda, Calif. He served his internship at the Los Angeles County Hospital and was resident physician at Queen's Hospital for the past year.

**Dr. Horold Johnson** returned from London where he attended the International Congress of Dermatology. Dr. Johnson has recently been elected a member of the American Dermatologic Association.

**Dr. Fred K. Lam** returned to Hawaii after a three months sojourn in Europe. While in Madrid, Dr. Lam attended the meeting of the International College of Surgeons.

**Colonel L. C. Boll** recently assumed his new duties as Chief of the Surgical Service at Tripler Army Hospital. Colonel Ball is a graduate of Washington University, St. Louis. He served his internship at the Union Memorial Hospital in Baltimore. He also served as a fellow in surgery at the Cleveland Clinic Hospital. He was Chief Surgeon at Schofield Barracks between 1939 and 1942 and served in the ETO with the 7th Army in evacuation hospitals in France and Germany.

**Dr. Horry B. Allison** has joined the Straub Clinic. Dr. Allison is a graduate of the University of Oregon. Prior to coming to Hawaii, he practiced in Tacoma, Washington. He is certified by the American Board of Orthopedic Surgery. He belongs to the American Academy of Orthopedic Surgery, the Western Orthopedic Society, and the North Pacific Orthopedic Association.

**Dr. Fronk H. Hotlelid** has been appointed head physician at the Waialua Agricultural Hospital. Dr. Hatlelid is a native of Groton, North Dakota. He is a graduate of the University of North Dakota and of Rush Medical College. He served his internship at St. Luke's Hospital in San Francisco, where he later became Chief Resident Surgeon. During World War II he served in the Army and was separated from the service with the rank of Lieutenant Colonel. Since 1946, he has been assistant physician to Dr. Davis.

**Dr. Richord C. Hitchen** announces the opening of his office at 369 Young Hotel Building. Dr. Hitchen is a graduate of Queenstown Medical School at Kingston, Ontario. He served his internship at the Vancouver General Hospital, followed by a two years residency at Queen's Hospital, Honolulu.

**Dr. Jomes Mornie** announces his association with Dr. L. A. Honl in the private practice of surgery.

Kapiolani Maternity and Gynecological Hospital welcomed four new members to the resident staff beginning July 1, 1952. **Dr. Robert B. Cochron** from Bismarck, North Dakota, is a graduate of Temple Medical School in Philadelphia. He served both at the Great Lakes and at Brooklyn Naval Hospitals. **Dr. Jock Woodruff** is a graduate of Ohio State University. He served as an intern at Indianapolis General Hospital and as a resident at Altman Hospital in Canton, Ohio, and at Kings County Hospital in Seattle, Washington. **Dr. Noboru Ogami** of Honolulu attended the University of Hawaii and received his medical education at the Boston University School of Medicine. He spent the past year on the resident staff of Queen's Hospital. **Dr. Vincent J. Battista** graduated from St. Louis University Medical School and later served on the staff of Harlem Hospital in New York City. He also served five years in the Army.

**Dr. Ross Hadden Ray** was recently appointed assistant physician at the Waialua Agricultural Hospital. Dr. Ray is a graduate of the University of Rochester, New York. He served both his internship and his residency at the Hartford Hospital, Hartford, Conn.

**Dr. Richard W. You,** one of the physicians with the U. S. Olympic Team, returned to Honolulu from Helsinki, Finland.

**Dr. Edward W. Boone** has joined **Dr. P. H. Liljestrand** at the South Shore Hospital, Aiea, Oahu. Dr. Boone was born in China and received his early education, through high school, there. He graduated from Harvard Medical School and served his internship at Lankenau Hospital in Philadelphia. He received his advanced training in surgery at the New England Deaconess Hospital in Boston and at the Rhode Island Hospital in Providence, R. I. He is certified by the American Board of Surgery. He is married and has three small children.

**Dr. Satoru Nishijima** has recently been certified by the American Board of Obstetrics and Gynecology.

Mr. and Mrs. Page Anderson announce the birth of their first son, Bruce Stetham, born June 28, 1952. Mrs. Anderson is the former **Dr. Elizabeth Kehrer.**

Queen's Hospital announces the arrival of the following members on their staff: **Dr. William Coey,** graduate of Northwestern University, Chicago, Illinois; **Dr. Lynn Frink,** graduate of State University of Iowa, Iowa City, Iowa; **Dr. Gordon Irwin,** graduate of McGill University, Montreal, Canada; **Dr. Grover Liese,** graduate of Washington University, St. Louis, Missouri; **Dr. Bunzo Nakagawa,** graduate of University of Oregon, Portland, Oregon; **Dr. George Oakley,** graduate of George Washington University, Washington, D. C.; **Dr. Linus Pauling,** graduate of Harvard Medical School, Boston, Mass.; **Dr. Irvin Rothrock,** graduate of University of Arkansas, Little Rock, Arkansas; **Dr. Daniel Whang,** graduate of Albany Medical College, Albany, New York.

(Residents) **Dr. Leabert Fernandez,** Assistant Resident in Surgery—graduate of Washington University, St. Louis, Missouri—internship at St. Louis City Hospital, St. Louis, Missouri—recently with Laupahoehoe Sugar Co., Laupahoehoe, Hawaii; **Dr. Wesley Shaw,** Assistant Resident in Surgery—graduate of University of Illinois —internship at Cook County Hospital; **Dr. Jack Fitzpatrick,** Assistant Resident in Medicine—graduate of Southwestern Medical College, Dallas, Texas—internship at Baylor University Hospital—residency at Lisbon VA Hospital, Dallas, Texas—recently on active duty in Army; **Dr. Virginia Payne,** Assistant Resident in Medicine—graduate of University of Wisconsin—internship at Wisconsin General Hospital; **Dr. Etsuko Toguri,** Assistant Resident in Medicine—graduate of University of Toronto—internship at Gallinger Municipal Hospital, Washington, D. C.; **Dr. Romeo de Grandpre,** Assistant Resident in Medicine—graduate of University of Montreal — internship at Notre-Dame, Hotel-Dieu, Misericorde, Montreal—previously in research at University of Montreal and the University of Vermont; **Dr. Mario Lopezllera,** Assistant Resident in Obstetrics-Gynecology —graduate of University of Mexico—internship at St. Barnabas Hospital, Minneapolis, Minn.; **Dr. Henry Traska,** Resident in Obstetrics-Gynecology—graduate of the University of Oklahoma—internship at St. Mary of Nazareth Hospital, Chicago, Ill.; (Special Fellow) residency in Obstetrics and Gynecology at University of California—previously general Practitioner; **Dr. Catherine Ohlandt,** Assistant Resident in Obstetrics and Gynecology—graduate of Woman's Medical College, Philadelphia—internship at Highland Alameda County Hospital, Oakland, Calif.; **Dr. Bella Hearst,** Assistant Resident in Pathology—graduate of Chicago Medical School, Chicago, Ill.—internship at Norwegian-American Hospital, Chicago—resident in pathology at Cook County Hospital, Chicago.

The following residents will continue in service: **Dr. Charles Judd,** Senior Resident in Surgery; **Dr. Francis Au,** Resident in Surgery; **Dr. Richard Lam,** Resident in Surgery; **Dr. George Mills,** Resident in Medicine; **Dr. Alexander Thomson,** Assistant Resident in Medicine; **Dr. William Nilssen,** Assistant Resident in Medicine (as of November 1, 1952); **Dr. Robert Browne,** Assistant Resident in Psychiatry; **Dr. Cora Au,** Resident in Obstetrics-Gynecology.

The following doctors from Hawaii are now in active military service in addition to those listed in the last issue of the HAWAII MEDICAL JOURNAL in Dr. Faus's annual report: **Drs. Nicholas M. Azzato, Edwin R. Ballard, Andrew C. Ivy, Keith F. O. Kuhlman, Kikuo Kuramoto, Rowlin L. Lichter, Samuel C. Y. Lui, Chew Mung Lum, Edmund C. K. Lum, Roy R. Ohtani, Kenneth H. Rusch, Shigeo Shinkawa** and **I. Sam Tashima.** Decisions as to availability for military service are made according to age, taking the youngest first, without regard to racial extraction.

## Hawaii

Since our last Journal notes, exclusive of the eruption of Halemaumau, nothing has happened except the following:

All the Hilo doctors have gone to see the eruption.

**Dr. Edwin D. Willett,** formerly of Naalehu, replaced **Dr. L. R. Fernandez** at Laupahoehoe Hospital on July 1.

**Dr. A. L. Vasconcellos** of Honolulu was the guest speaker at a recent Hawaii County Medical Society meeting.

**Dr. G. H. Lambert** is now the head of the Department of Radiology at the Hilo Memorial Hospital. He is a graduate of the State University of Iowa College of Medicine and interned at the Maine General Hospital in Portland. He engaged in general practice in Winthrop, Maine for ten years and served in the U.S. Army Medical Corps from 1942-46. The following year he spent in Shanghai. From 1947-50 he was a resident in radiology at the Veteran Center, West Los Angeles. He also served there two years as staff radiologist and was consultant at Harbor General Hospital.

After 21 years of medical practice, **Dr. Clyde L. Phillips** has decided to close his office indefinitely due to illness. Here's hoping he recovers soon!

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## Kauai

Congratulations to the local G. P.'s who recently formed the Kauai Chapter of the Academy of General Practice. The charter members are **Drs. Wallis, Fujii, Ishii, Goodhue,** and **Cockett.**

Recent visitors to the home of Madame Pele were **Drs.** and **Mesdames Cockett, Ishii** and **Wallis.**

The Society welcomes the return of **Dorothy Kemp,** our County Health Officer, who completed her requirements for a master's degree in Public Health at the U. of California. She says there's no place like Kauai and is happy to be back.

**Bill Goodhue** is too busy to take vacations. **Kenneth Fujii** says maybe, and **Burt Wade** speaks in the past tense only.

Recently some of our local physicians conducted post graduate sessions at **Sam Wallis'** home. Some members feel that this has been well worthwhile, others have no comments as yet. All visitors to these sessions in the future will be welcome.

## NEWS

### Essay Contest

The American Dermatological Association is offering a prize of three hundred dollars for the best essay submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. Manuscripts typed in English with double spacing and ample margins, with illustrations, charts, and tables, all of which must be in triplicate, are to be submitted not later than January 1, 1953. They should be sent to Dr. Louis A. Brunsting, Secretary, American Dermatological Association, 102-110 Second Avenue, Southwest, Rochester, Minnesota.

### Civil Defense

The Council on National Emergency Service of the American Medical Association has sponsored a series of articles on the medical aspects of civil defense which appeared in the Journal of the American Medical Association. These articles have now been reproduced in booklet form. They sell for 25¢ a single copy, and 20¢ per copy for orders of 100 or more.

**Dr. R. J. McArthur** has appointed a Nominating Committee for the Hawaii Territorial Medical Association and requested that their names be printed in the JOURNAL so that any member of the Association having any specific candidate in mind for 1953 may be able to express his wish to one of the members of the committee.

NOMINATING COMMITTEE

**Dr. Robert Benson,** chairman
**Dr. Joseph Palma**
**Dr. Isaac Kawasaki**
**Dr. A. V. Molyneux**
**Dr. Samuel Wallis**
**Dr. Archie Orenstein**
**Dr. William Wilkinson**

# UMI MAKAHIKI I HALA*

This issue was devoted to a symposium, "Disposition of War Casualties," including the following articles:

*War Wounds*
A. W. Spittler, Lieutenant Colonel, M.C., U.S.A.

*Shock*
C. T. Young, Lieutenant Colonel, M.C., U.S.A.

*Abdominal War Wounds*
L. D. Heaton, Lieutenant Colonel, M.C., U.S.A.

*Chest Wounds*
J. E. Strode, M.D.

*Head Injuries*
Ralph B. Cloward, M.D.

*Orthopedic Wounds*
J. D. Macpherson, Lieutenant, M.C., U.S.N.R.

*Burns: A Treatment Plan for Large Numbers*
Paul C. Spangler, Lieutenant Commander, M.C., U.S.N.R.

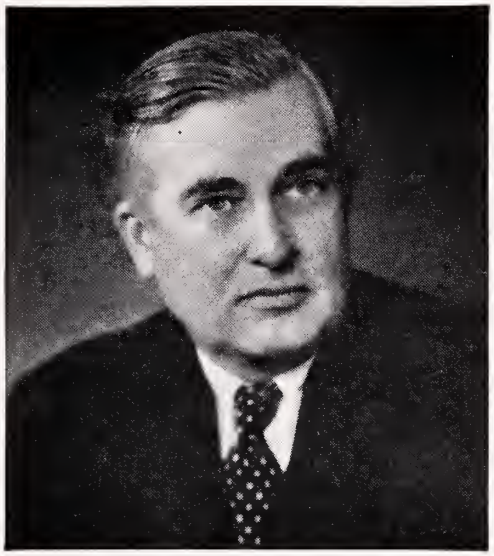
*Blast Injury of the Lungs*
*With Comment on Immersion Blast Injury*
Joseph Palma, Lieutenant Commander, M.C.-V(S), U.S.N.R.

* Ten years ago. From Volume 2, Number 1, September-October, 1942.



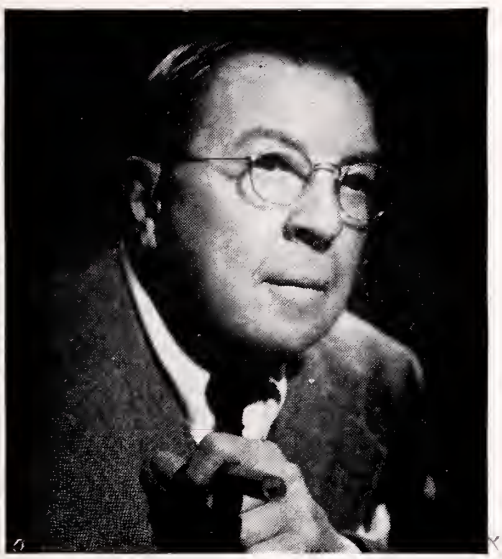
**MRS. ELEANOR ROOSEVELT**

World-famous wife and mother; Senior United States Representative of the United Nations General Assembly; author, radio and television commentator; internationally respected and admired for her interest in, and understanding of, all peoples.



**HONORABLE CHARLES EDISON**

Son of the late Thomas A. Edison; former Assistant Secretary and then Secretary of the Navy; former Governor of New Jersey; guiding force as officer and/or director in many nationally known civic, educational and industrial organizations.



**MR. RUPERT HUGHES**

Author, playwright, producer, poet, biographer, composer; chief assistant editor of the 25-volume History of the World published by Encyclopaedia Britannica; veteran of two world wars; Hollywood writer, Doctor of Letters, director and commentator.

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# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAM, *Executive Secretary,* Honolulu

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## PRESIDENT'S MESSAGE

Time is marching on and our annual meeting will soon be here. The fliers announcing the program for the convention will be mailed to you in a few weeks.

In this issue of the bulletin you will find highlights of recent meetings of your Board of Directors. The publication of the actions of the Board has been adopted as a policy for the future. This will be one way of sharing our responsibilities and problems with you.

It is so important this year that every member be a thinking, participating member. It is also vital for every nurse to acquaint herself with facts so that she can participate intelligently in solving these problems.

Our finance committee has worked hard to prepare a budget for the year of 1952-1953. The Territorial Association is trying to absorb the $2.00 increase per member which will have to be sent to the A.N.A. so as *not* to increase the amount of your dues. In doing so we will have a deficit unless a larger membership of nurses participates in meeting these needs. In almost every committee meeting recently, the payment of dues has been discussed. Would more nurses respond to "Roll Call" if we could work out a satisfactory regular interval payment plan of dues?

Let us be nurses who think together—who work together. Only as we participate in this way can we make our organization successful.

ARLENE N. THOMPSON, R.N.

## NURSING REORGANIZES

Nursing has a new national organizational structure. Instead of the six national organizations that have been concerned with professional nursing, there are now three: the American Nurses' Association, the National League for Nursing, and the American Association of Industrial Nurses.

The need to coordinate national effort in nursing has been repeatedly demonstrated during the past twenty-five years—but never more acutely than during World War II. In spite of heroic efforts to cover essential needs and to employ practical nurses and auxiliary personnel, civilian nursing services could not hold to peacetime standards. Through recruitment, the nurse supply increased tremendously but not rapidly enough to keep pace with the phenomenal upswing in the demands for nursing service.

To make it possible for the six national organizations concerned with professional nursing to work closely with one another as well as with other groups in the war effort, the National Nursing Council for War Service Inc. was organized. This was later renamed the National Nursing Council.

After the end of World War II the council was dissolved. A joint board of directors of all six organizations was then set up. This arrangement has worked well. But the ever-mounting demand for nursing service and the possibility of having to meet civilian and military needs in an atomic crisis reminds nursing that it is essential to have

a more closely knit organizational structure in which nurses, allied professional workers, and other citizens concerned with nursing can move forward together with maximum speed and efficiency.

### Planning for Reorganization

The first definite step in planning for reorganization was taken in 1944. At that time, the board of directors of the American Nurses' Association (ANA), the National League of Nursing Education (NLNE), and the National Organization for Public Health Nursing (NOPHN) voted to undertake a joint survey of their "organization structure, administration, functions, and facilities to determine whether a more effective means can be found to promote and carry forward the strongest possible program for professional nursing and nurses."

During 1945, the Association of Collegiate Schools of Nursing (ACSN), the American Association of Industrial Nurses (AAIN), and the National Association of Colored Graduate Nurses (NACGN) joined in the reorganization study. (Although this last organization was dissolved in 1951, it continued to be represented on the national structure committees.)

Since 1945 thousands of persons have carried forward the search for a structure that would provide greater unity for nursing organizations and their programs. Many committees—national, state, and local—have been hard at work. A formal study and report were made by a public relations firm specializing in membership organizations. In 1946, several plans were proposed and workshops were held throughout the country. "Structure" soon became a national byword in nursing.

Before any real progress could be made, however, one major question had to be answered. This was: "Does nursing need one or more organizations?" For a while, opinion was divided. A few persons thought that the current number of organizations were needed. Some believed that nursing would best be unified if there were only one organization. Others believed that two organizations were necessary. Gradually, this last point of view gained general favor.

In 1950, all six participating groups voted to realign into two organizations; later however, American Association of Industrial Nurses withdrew. They asked national committees to work out the details of a plan so that it would be ready for action by the members during the summer of 1952. It was understood that one of the organizations would be the American Nurses' Association and that it would continue to be an all-professional nurse organization exclusively for professional nurses. The other was to be a new organization for all those interested in improving nursing services and education—nurses and non-nurses alike.

### ANA in the New Structure

In the new organization plan, the American Nurses' Association (ANA) will promote the professional, general, and economic welfare of professional nurses and help them become the best possible practitioners as individuals and as members of a profession.

Among many other activities, the ANA will:

1. Define the functions of nurses and promote standards of professional nurse practice.
2. Define the qualifications for the practitioners of nursing, including those in the various nursing specialties.
3. Promote legislation and speak for nurses in regard to legislative action concerning general health and welfare programs.
4. Survey periodically the nurse resources of the nation.
5. Provide professional couseling service to individual nurses in regard to vocational and educational opportunities and to employers of nurses in regard to available nurse personnel.
6. Represent nurses and serve as their national spokesman with allied professional and governmental groups and with the public.
7. Serve as the official representative of American nurses in the International Council of Nurses.

Although the ANA will be a continuing organization, a number of changes in its present structure will be made. Chief among them are those that concern ANA sections and the House of Delegates.

The revised plan for the ANA provides sections for the following groups: (1) private duty nurses, (2) general duty nurses, (3) public health nurses, (4) institutional nursing service administrators, (5) educational administrators, consultants, and teachers, (6) industrial nurses, and (7) unaffiliated or special groups section.

ANA sections, each of which in the past was primarily a conference group of nurses working in a special occupational field, will now have more extensive programs and much greater responsibility. Among other things, each will define the functions, standards, and qualifications for practice within the occupational field in which the members of the respective section work. For instance, members of the Private Duty Nurses' Section will define the functions, standards, and qualifications that are desirable for practice as a private duty nurse. In a section of their own, general duty nurses (hospital staff nurses) will define their own functions, standards, and qualifi-

cations; public health nurses will define theirs; and so forth.

Sections in the state nurses associations will be strengthened by having proportional representation in the ANA House of Delegates—the official voting body of the members which meets every two years. At present, a state nurses association as a whole, rather than its sections, is represented in the ANA House of Delegates. Besides section representation, there will also be three delegates at large from each state and territory.

Students of professional nursing will be members of a student council which will be affiliated with the Coordinating Council, and will not at this time be incorporated as a section of ANA. They may take part in some general ANA activities although they will not actually be ANA members.

### The New Organization

"National League for Nursing"—or, more briefly, "NLN"—is the name of the *new* national nursing organization. It will replace and carry forward the major programs of three of the former groups: The Association of Collegiate Schools of Nursing, the National League of Nursing Education, and the National Organization for Public Health Nursing. The American Association of Industrial Nurses voted to remain a separate national organization. In addition, the NLN will assume responsibility for activities in nursing never before fully developed.

The NLN will be unique among membership organizations in the United States, and—so far as is known—anywhere in the world. Through the NLN it will be possible for nurses who give direct care to patients, as well as other nurses, administrators, board members, allied professional workers such as physicians, and consumers, to work together to develop and improve organized nursing services in communities. Through the NLN it will also be possible for nurses in all occupational fields and positions, teachers, other educators, administrators, and consumers to work together to improve education for nursing so that nurses will be prepared to give the kind of service the people need. In brief, the NLN will be a "community-centered" organization where the points of view of nurses and other citizens, both as individuals and as representatives of community health and educational agencies, will be pooled to bring about coordinated action in nursing for the common good.

Among many other activities, the NLN will:

1. Define and promote standards for organized nursing services and guide communities in achieving these standards. (Organized nursing services include those provided by hospitals, industries, schools, visiting nurse associations, health departments, and other community agencies.)
2. Promote education for nursing in all fields by defining and developing sound standards of nursing education, and guide educational institutions in achieving these standards.
3. Promote the extension and proper distribution of facilities for organized nursing service and education throughout the country.
4. Represent organized nursing services and nursing education units and serve as spokesman with allied professional, governmental, and international groups and with the public in regard to matters related to the purpose of the National League for Nursing.
5. Accredit educational programs in nursing.

The work of many national committees and services that now are jointly sponsored by two or more of the present organizations will become part of the NLN program. These include the Committee on Careers in Nursing which is working on the recruitment of nurse students, the National Committee for the Improvement of Nursing Services, the Joint Committee on Nursing in Medical Care Plans, the Joint Committee on Practical Nurses and Auxiliary Workers in Nursing Services, the National Nursing Accrediting Service, the Joint Orthopedic Nursing Advisory Service, and the Joint Tuberculosis Nursing Advisory Service.

Both individuals and agencies will be eligible to join the NLN. Individual members will include professional nurses in all fields of, and positions in, nursing; members of boards and committees associated with nursing services and educational units; members of allied professional groups; and other citizens who are interested in seeing that there are sound standards for nursing service and education.

NLN agency members will include: nursing services organized in hospitals, convalescent homes, and other institutions; nursing services in industries, visiting nurse associations, health departments, and other community agencies; and schools and programs for nursing education whether associated with a hospital, college, or university. Collegiate schools of nursing and public health nursing units—especially visiting nurse associations—have been participating in their own national nursing organizations for many years. But it will be the first time that the other groups will have the opportunity to join a national organization dedicated to developing and improving both organized nursing services and organized education for nursing.

### NLN Departments

In developing the plan for the National League for Nursing, it was recognized that attention would need to be focused on special as well as on general problems and interests. It would be essential to have not only unity but enough diversity within that unity, to permit stimulation and growth of various phases of nursing.

Accordingly the new organization will have two membership divisions—the Division of Nursing Services and the Division of Nursing Education. In the first division there will be two departments: Department of Hospital Nursing, and Department of Public Health Nursing. In the Division of Nursing Education there will be two departments: Department of Diploma and Associate Degree Programs, and Department of Baccalaureate and Higher Degree Programs.

In addition to the four departments, there will be two major types of councils—departmental and interdivisional. A departmental council will be composed of agency members within a specific department—for example, a council of public health nursing services within the Department of Public Health Nursing. In such a departmental council, agency member representatives (who will include both nurses and people who are not nurses) will be able to confer on matters that are of special interest to them, recommend to the board of directors new programs that should be carried out, and help carry forward the NLN program so far as it directly concerns that specific group of agencies. An interdivisional council will be composed of individual members who are interested in both the service and educational aspects of a special subject—such as tuberculosis, maternal and child health, orthopedic, or school nursing.

### Practical Nursing

As plans for the new structure progressed, representatives of the national nursing organizations became increasingly aware that, to achieve its objective, the NLN should plan for the development and improvement of *practical* as well as *professional* nursing service and education.

Many potential NLN agency members—in particular, visiting nurse associations and hospital nursing services—employ practical nurses to help supplement the care given by professional nurses. In this way, the agencies are able to provide the community with more extensive service than would otherwise be possible in these days when there is still far greater demand for nursing care than there are nurses to give it. When considering the administration of nursing service in these agencies and what can best be done for the patient's welfare, professional and practical nursing should be considered in close relation. Also, since the service given by practical nurses supplements that given by professional nurses, the standards for practical nursing education need to be developed within the same organization that is concerned with standards for professional nursing education.

A special committee will guide the NLN program as it relates to practical nursing. This committee will continue the work of the present Committee on Practical Nurses and Auxiliary Workers in Nursing Services which has been jointly sponsored by all six national nursing organizations. Members of the new committee will include representatives of both the National Federation of Licensed Practical Nurses and the National Association for Practical Nurse Education. The groups responsible for developing the NLN plan hope that by 1953 or 1955 there will be a special department for schools of practical nursing in the NLN Division of Nursing Education. The House of Delegates voted to have the practical nurse needs studied in relation to the functions of NLN and then to consider practical nursing membership in NLN at the national meeting in 1953.

### State and Local Units

Both the ANA and NLN will have state and local or district units. The ANA will continue to be a federation of state nurses associations. Most of these state associations are divided into districts so that members may carry forward a well-developed and direct program in addition to state and national programs.

The National League for Nursing, too, will have constituent units in the states, and a State League for Nursing will have district units. It is intended that a State League for Nursing will take the place of any and all of the following groups that may now be organized in a state: State League of Nursing Education, State Organization for Public Health Nursing, and a State Committee on the Improvement of Nursing Services. (The Association of Collegiate Schools of Nursing does not have state units.)

### Conclusion

Realignment of the national nursing organizations will make it possible for nursing to achieve close coordination of effort and at the same time preserve the diversity which stimulates the growth of various phases of nursing. Through a two-organization structure nurses, members of allied professional groups, and other citizens will be able to work together more effectively toward a common goal—better nursing care for the people.

## 40 HOUR WEEK

Beside the adoption of a new national nursing structure at the Biennial Convention in Atlantic City, June 1952, an additional highlight was the resolution calling for a forty-hour week for professional nurses, passed upon by the House of Delegates, American Nurses' Association.

The resolution, as presented, is stated below:

WHEREAS, The 40-hour week is a highly effective economic and social inducement for employed nurses to remain in their present positions, for inactive nurses to return to duty, and for prospective students of nursing to enter the profession; and

WHEREAS, Nurses throughout the country have clearly expressed their desire for the 40-hour week, as ordered by their delegates in the official pronouncements of the American Nurses' Association, and as evidenced by the employment standards promulgated through state nurses associations; and

WHEREAS, The 40-hour week is accepted as the basic workweek for the great majority of employed groups throughout the United States of America; and

WHEREAS, The experience of institutions and agencies employing registered professional nurses has proved the 40-hour week to be a valid, feasible and effective method for meeting the problems of staffing, recruitment, and turnover; therefore be it

*Resolved,* That this House of Delegates of the American Nurses' Association calls on all employers of registered professional nurses to put into effect the 40-hour week as the basis of payment for registered professional nurses, without reduction in salary, and with the request that employers make every effort to explore all such policies and practices as will make possible the institution of the five-day, 40-hour week, with two consecutive days off, as the standard work week for registered professional nurses; and be it further

*Resolved,* That any work by registered professional nurses beyond the 40-hour week be compensated on the standard basis of time-and-one-half; and be it finally

*Resolved,* That the House of Delegates urge every nurse, through her local section, district nurses association and state nurses association, to work for immediate implementation of the 40-hour week as set forth in this resolution.

* * *

A printed report from the Hawaii Delegates who attended the Biennial Convention will be available to members of the Nurses' Association, Territory of Hawaii, at its annual meeting in October.

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## ACTIONS OF YOUR BOARD OF DIRECTORS

### April 1952—Sub-NATH Board. Minutes are sent to Directors on Hawaii, Kauai and Maui.

**Voted** to publish in the INTER-ISLAND BULLETIN a resume of pertinent facts from meetings of the Board of Directors.

**Discussed** possible delegates to Biennial in Atlantic City. Executive Secretary to be sent by the Board for the Licensing of Nurses. Each district to be asked to send leis for delegates for one day.

**Voted** to give Mrs. Rosie K. Chang $500 for partial expenses to Biennial, this being the first time NATH has underwritten expenses for Mrs. Chang.

**Discussed** need for study of scholarship available to nurses. This seemed to be a logical project of the Careers Committee of the League.

**Discussed** the number of delinquent members who are officers in the Association.

**Decided** to give no instructions to delegates to Biennial.

**Discussed** a request that nurses be permitted to subscribe to the INTER-ISLAND BULLETIN rather than having the cost of the subscription as a part of the dues. Guarantee of total membership participation was a part of the agreement when the Medical Association took over the publication.

### June 1952—Full Board.

**Heard** NATH Committee reports.

**Discussed** budget for 1953 in relation to ANA dues increase from $3 to $5.

**Heard** report of Biennial given by Executive Secretary. Delegate representation:

| | |
|---|---|
| Mrs. Rosie K. Chang | $500 |
| Miss Clara Mitchell | 250 |
| Miss Eileen MacHenry | 100 |
| Miss Dorothy Sakamoto | 115 |

A report from the delegates will be included in the written reports distributed at the Annual Meeting.

**Discussed** change in private duty rates in Nursing Service Bureau. These to be sent to the district presidents.

**Discussed** problems presented by Director from Hawaii.

**Discussed** a request that NATH participate in bringing practical nurse students from Guam to Hawaii to further their education. The cost to be $350 for NATH. Since this was not included in the budget, the Board felt NATH could not participate at this time.

**Read** a letter from the President, Mrs. Thompson, to the Board of Salary Standardization requesting disapproval of some of the items in the Gallas report for civil service reclassification.

**Selected** the names of Mrs. Patience Martelon and Miss Alison MacBride from the list of names suggested by the League to fill a vacancy arising on the Board for the Licensing of Nurses. These names to be submitted to the Governor for his consideration.

**Moved** that a special committee be appointed for compiling NATH policies.

**Moved** to have NATH committee reports mimeographed for distribution at the Annual Meeting.

**Moved** to have proposed revisions of by-laws mimeographed for distribution to membership. These to be drawn up according to ANA revisions.

### July 1952—Sub-NATH.

**Studied** proposed revisions of NATH by-laws. This to be brought back to the Board.

**Studied** the discrepancy between by-laws which state that two directors are to be elected each year and the fact that only one director's term expired this year.

**Voted** to elect two directors this year as per by-laws, but to send this decision to the districts for approval.

**Accepted** 1953 budget which is to be sent to districts for

study and then to be brought before the House of Delegates at the Annual Meeting.

**Moved** that funds to cover the deficit on the 1952 budget must be sent by the districts to the treasurer of NATH by September 15.

## PROGRESS REPORT ON THE UNIVERSITY SCHOOL OF NURSING

VIRGINIA JONES*

Four months have passed since, on April 1, the last bit of money was obtained and the School of Nursing at the University of Hawaii was officially established by the Board of Regents of the University. Much has taken place since that time in preparation for the first class of students in September.

Announcements were prepared and 700 of them soon found their way into schools and into the hands of advisors and prospective students. More than 120 applications were received. Of that group, 30 were accepted. Each of these students understands that her further continuance in the school depends upon her performance during the two semesters of the first year. The program is planned so that she may easily transfer to another curriculum if desired. Students have been selected with their ability to participate in student government activities also in mind, since this first group of students will be called upon to make group decisions regarding uniforms, pins and the like, and to formulate student government policies.

One faculty member will soon be on her way from the mainland. Her first task will be to formulate plans with individual agencies for clinical practice which will start in a small way in the summer of 1953. Plans are made to add faculty members in 1953 for medical and surgical nursing, psychiatric, tuberculosis and public health nursing. In 1954 others will be added for obstetric and pediatric nursing. These will be both full-time and part-time instructors, some being physicians. Included in the budget being asked for the biennium will be eight full-time and at least seventeen part-time instructors for nursing courses. This does not include instructors in courses which nursing students take with other students.

The school office is now located in the building set aside for the School of Nursing—Hale Aloha. Besides the school office with a full-time secretary, there will be a 12-unit nursing arts laboratory and utility room, a classroom equipped with movie and slide projectors and screen, a seminar and conference room with kitchen attached, four offices, storeroom and student restroom. Equipment for these rooms is here or will arrive before school starts in September.

The curriculum is outlined in the *University Bulletin* for 1952-53 and in the school announcement. Final details of the last three years are awaiting consideration by the faculty, including representatives from clinical practice agencies.

The Student Health Service will provide health examination, testing and immunization service to suit the needs of the school.

The present courses for graduate nurses will be continued in the school. However, it is hoped that when the faculty is adequate, a testing program for graduate nurses can be developed. Graduate nurses may then have programs for completing their degrees planned according to their individual needs with more credit given for their basic nursing work when justified by test results.

* Director, School of Nursing, University of Hawaii

## JOIN YOUR HMSA

The Hawaii Medical Service Association, Blue Shield for Hawaii, is a plan of prepaid medical service governed by its members. The HMSA began in 1938 with a nucleus of less than 1,000 members. At the close of 1951, the membership had grown to 52,863 members. This is over 11% of the total population of the islands.

The Association is non-profit, and pays no Territorial or Federal taxes; it exists solely for the purpose of administering a plan of health protection between the medical profession and its membership. Any excess of funds earned by the plan must be returned to the membership in the form of additional benefits. As an outstanding example of this, the group within the Nurses' Association for the year of 1951 paid in dues to HMSA $3,004.06 and received in benefits from HMSA $3,233.40.

Your HMSA group plan offers a program of four point health protection:

1. A liberal plan of hospitalization including 30 days per year at full ward rate with many additional in-patient benefits.
2. A substantial program of indemnity for maternity care.
3. A complete and standard fee schedule for surgery, with guaranteed full coverage for those in the three and four thousand dollar a year income brackets.
4. Coverage for doctors' office, home or hospital calls.

Your plan is open semi-annually to you, your spouse and your eligible children. No physical examination or medical statement is required. You may transfer among local groups as well as to mainland Blue Shield plans.

Those nurses who have not joined the HMSA where they are employed, may join through the Nurses' Association. For additional information and applications, contact the office of the Nurses' Association, District of Oahu, Telephone 52-2255.

## COMMUNITY SERVICE THROUGH TEACHING

LORETTA T. SCHULER*

More than ever before, the citizens of the Territory of Hawaii are asking for training in the principles and practice of home nursing. This upsurge in interest in home nursing technic is due in part to revived interest in civil defense preparedness.

Because the American Red Cross has had long experience in the field of civil defense and has ready made machinery in its chapters through which it can reach large numbers of people, it has been especially charged by the National Security Resources Board with the responsibility of implementing and speeding up the home nursing training program. This program includes the training of mothers and fathers in Mother and Baby Care and Family Health; men, women and high school students in Home Care of the Sick and Injured; and men and women over 21 years of age to assist in hospitals, public health agencies and aid stations as volunteer nurse's aides.

During the past fiscal year Hawaii Chapter, American Red Cross Nursing Services has accelerated the home nursing program in order to meet this national request. With a small corps of paid staff members and interested professional nurse and non-nurse groups, 1,470 persons have been trained in Home Care of the Sick and Injured technic during the 1951-1952 fiscal year; 1,458 have been trained in Mother and Baby Care and Family Health; and 71 Volunteer Nurse's Aides have completed train-

* Director, Nursing Services, Hawaii Chapter, American Red Cross

ing. A total of 2,999 persons have been trained to care for themselves and others in the event of illness in the home, or in time of natural-caused or war-caused disaster.

Hawaii Chapter American Red Cross Nursing Services would have been unable to train such a vast number of persons had it not been for the cooperation of other agencies and for the generosity of nurse volunteers who gave willingly of their time and talents to the Red Cross home nursing training program. Credit is due the Bureau of Public Health Nursing and the public health nursing staff, St. Francis Hospital Out-Patient Clinic and The Queen's Hospital Out-Patient Clinic for the proficient training given to many expectant mothers and fathers in Mother and Baby Care and Family Health. Credit is due the University of Hawaii School of Nursing for training public health nursing students as Mother and Baby Care and Family Health instructors.

Individual thanks go to the following Public Health nurse instructors who taught Mother and Baby Care and Family Health classes during the current fiscal year: Mesdames Jane Oki, Helen Williams, Josephine Wong, Gloria Foster, Marion Kawata, Flora Ozaki, Janet Toda, Okuni Tanner, Toshiko Ono, Margaret Makekau, N. Shiroma, Alvana Chang Lee, Sakae Kawakami, Yuki Izumo, Ruth Martin, Joyce Fujiki, Lillian Mau, Hatsumi Ishikawa, and Misses Rachael Todd, Muriel Oshiro, Dora Lum, Hideko Nishihara, H. Yoshioka, Agnes Parrish, Jo Ann Groberg, Mildred Kiyuna and Hazel Kanemoto. Other registered nurses who have taught Mother and Baby Care and Family Health classes during 1951-1952 are: Mesdames Michiko Chinna, Mabel L. Davis, Florence Marks, Helen Menezes, Grayce Plumstead, Alice Kohler, Myrtle Schattenberg, Flora Wheelwright, Annabelle Mongeon, Clara Ishikawa, and Misses Rosemary Biss, Lillian Gima, Wilma Porter, Yetta Ishiki and Virginia A. Jones.

The success of the Home Care of the Sick and Injured program may be attributed for the most part to institutional, private duty, school, office and retired nurses who were interested in the home nursing program and community welfare. The following Red Cross nurses taught Home Care of the Sick classes during the past fiscal year: Mesdames Audrey Berrington, Michiko Chinna, Mary Caires, Mabel L. Davis, Clara Ishikawa, Marjorie Kiyosaki, Jane Oki, Myrtle Schattenberg, Isabel Medeiros, Effie Moller, Florence Marks, Beverley Juilfs, and Misses May Bowron, Olive Casscells, Winifred Golley, Alice Iwamoto, Mildred Kushima, Yetta Ishiki, Kyoko Nagatani, Muriel Oshiro, Martha Rothwell, Marie Sharp, Loretta Schuler, Lily Wakahiro, Lillian Gima, Virginia A. Jones and Louise Ishii. Thirteen professional nurses from the county of Hawaii taught Home Care of the Sick and Injured classes. They are: Mesdames Diedre Bockus, Edna Baldwin, Lois Cummings, Elizabeth Stillman, Nettie Morimito, Mae Marcallino, Irene McLane, Hatsumi Ishikawa, and Misses Jettie Jacobson, Yukie Katada, Sumiko Kumabe, Dora Lum and W. Irene Riley. Nurses from Kauai who have taught Home Care of the Sick and Injured this past fiscal year are: Miss Myrna Campbell, Red Cross instructor-trainer, Misses Helen Hetrick, Thelma Hensley, Edythe Kamida, and Mesdames Cecile Buddingh, Louise Lawrence, Josefina Cortezan and Evelyn Giles.

Institutional and retired nurses played the major role in the Volunteer Nurse's Aide training program. Both volunteer hospital nurses and retired nurses gave freely of their time to train volunteer nurse's aides in nursing fundamentals. Hospital nursing supervisors and staff nurses helped to complete the course by supervising the 40-hour job-training phase. Without assistance from St. Francis, The Queen's, and Kuakini general hospitals on Oahu; Wilcox and Waimea hospitals on Kauai; and Hilo Memorial on Hawaii, Red Cross would have been unable to train volunteer nurse's aides for service.

Nurses who have taught the 36-hour volunteer nurse's aide classroom instruction phase since July 1, 1951 are: Mesdames Beverley Juilfs, Marie Kusunoki, Beth Rider Polson, Florence Marks, Irene Zane and Leila Miyamoto of Oahu; Roberta Faye of Kauai; and Misses Frances Kupau and Marion Bowes of Oahu.

Because of the multiplicity of demands upon the time of professional nurses, Red Cross has in the past depended largely on volunteer nurse instructors who were not active in nursing. The increasing interest in Home Care of the Sick, Mother and Baby Care and Volunteer Nurse's Aide training, however, has made it necessary to appeal to the employed nurse group for additional assistance. Employed nurses have responded readily to the Red Cross appeal. Many are now, as Red Cross distinguished them, "nurses plus," that is, they are giving volunteer time to community service beyond the line of duty. Red Cross is grateful to the "nurse plus" group and to the retired nurses who served as volunteers during the past fiscal year. The program would not have been successful without them. Nursing Services extends the appeal for assistance with the home nursing training program to professional and retired nurses who are not active in Red Cross in order that they might swell the ranks of "plus nurses."

## REPORT OF LIBRARY COMMITTEE

VIRGINIA JONES*

Mabel Smyth Medical Library is being increasingly used by nurses. The Committee feels that it is time some definite policies for keeping nursing material up-to-date, easily accessible, usable and in nurses' awareness should be formulated.

Schools of nursing have their own libraries for students and the library of the University of Hawaii is available for nurses taking courses there. In view of these facts, the Committee recommends that

(1) emphasis be put upon the needs of graduate nurses in in-service education programs, instructors, supervisors and administrators.
(2) there be a broad distribution of areas represented in the material obtained.
(3) material intended for lay persons not be included (because of limitations of both money and space).
(4) pamphlet material be increased and appropriately filed.

Books, periodicals and pamphlets will be selected with these policies in mind. Plans have been made with the library to bind, file and place nursing periodicals, books and pamphlets so they will be more easily accessible. Catalogues from universities and colleges offering programs for graduate nurses will be collected and kept current.

Funds for buying books and for binding and files have been given the Association by the Margaret Jones Memorial Fund.

Attempts will be made to review at least two new books or pamphlets in each issue of the BULLETIN and to include a list of all new nursing books received by the Library.

* Chairman, Library Committee

Only members of the Territorial Nurses' and Medical Associations are entitled to borrow books. Any nurse may read in the Library itself.

The Committee is now in the process of organizing statements of policies which can be printed and kept on file for reference.

The Committee needs the help of all Association members to suggest new books and pamphlets appropriate for the Library, to review new books for the BULLETIN and to suggest ways in which the nursing material can be made more usable. Send us your suggestions, please.

* * *

## BOOK REVIEW

*The Nurse of Tomorrow*—A Study of Nursing in Hawaii. Territorial Commission on Nursing Service and Nursing Education. 20 pp. 1952.

What will nursing of tomorrow be like in Hawaii? What is it like now? What must be done to make it adequate for the future?

These questions are discussed in a 20-page booklet published for general distribution by the Territorial Commission on Nursing Service and Nursing Education. The contents are based on a report of a survey of nursing needs and resources made by Miss Ruth Gillan of the Division of Nursing Resources of the Federal Security Agency in 1951. The Commission, authorized by the Legislature and appointed by the Governor, has been given the responsibility of implementing the findings of the report. It points out significant facts and recommendations in the booklet.

Hawaii is now a debtor to other states because it prepares only about one-half of the graduate nurses needed in the Territory. Even though the over-all nurse-patient ratio is above the recommended average, more nurses than are now employed in the Territory would be needed if the publicly supported hospitals—especially the Territorial Hospital—were adequately staffed, industrial health programs were consistently developed and the number of public health nurses were in recommended ratio to the population.

Only one-third of the 1200-odd practical nurses registered and employed in the Territory have had training and have been licensed by examination. Yet more trained practical nurses are needed. Expansion of facilities to allow increased admissions to the Practical Nursing School and an extension program to give training to those already licensed by waiver are badly needed.

Most of the advanced teaching and administrative positions in nursing in the Territory are held by nurses from the mainland. This is because the local graduates have not been able to go to the mainland for the necessary preparation. Since the number is relatively small, it is not practical for advanced educational programs to be developed at the University of Hawaii. Greater scholarship funds for mainland study in supervision, administration, teaching and special clinical areas are needed.

Hawaii's programs for preparing nurses are in the highest 25 per cent in the nation. These hospital school graduates consistently rate high in the nationally standardized licensing examinations. To give island girls opportunity for collegiate education in nursing equal to that offered to women in all but eight of the states, full development of the School of Nursing at the University of Hawaii is recommended. Its graduates will be prepared to embark upon programs of graduate study increasingly being required for positions in teaching and administration.

Salaries, vacations and the like, as well as opportunities for in-service education, are unequal in private employment and in Civil Service positions throughout the Territory. Correction of these inequalities and a hospital nursing consultant to help in developing educational and supervisory programs for improvement of nurses on the job are recommended in the report.

While we may well be proud of the development of nursing in Hawaii thus far, there is much to be done by nurses, legislators, employers and educators.

Copies of this report may be obtained from the Territorial Commission on Nursing Service and Nursing Education, Mabel Smyth Building, Honolulu.

VIRGINIA A. JONES, R.N.

*The Education of Nursing Technicians.*
By Mildred L. Montag. 146 pp. Price $2.50. G. P. Putnam's Sons, New York, 1951.

In this study, which is offered as partial fulfillment for her Doctor of Education degree, Miss Montag makes a case for a new category of nurses. She suggests the name "nursing technician." She offers facts with which we are all familiar to prove that many more people are needed to give nursing service, and that there will never be enough professional nurses to carry the load. Nor does she think collegiate prepared professional nurses should be required to provide routine nursing care where judgment and highly specialized skill are not necessary.

As she points out, Brown in the *Future of Nursing* and other authorities have stated that the nurse graduated from the three-year hospital school——the Registered Nurse—is not adequately prepared to carry out the complex functions at one extreme of the range of functions required of the modern nurse, whereas the practical nurse school graduate can do little more than the aide trained on the job. There is no specific provision made for the group of functions in between. In this book, Miss Montag suggests a worker called "nursing technician" to take the place of both the three-year graduate and the practical nurse, who will work in a team with the collegiate prepared nurse and the nurse's aide to plan care for patients according to their individual needs and the workers' skills.

With educational authorities and the President's Commission on Higher Education to back her, the author recommends that such programs be developed in community or junior colleges, where the student may have a curriculum of general and technical courses designed to prepare her for taking her place in society as well as for performing in the nursing situation. She suggests a type of two-year curriculum for this purpose which would lead to a degree of associate of Arts or Applied Science—both of which are already frequently granted for terminal courses in other fields. She gives suggestions also for courses for professional nurses preparing to teach in this type of program.

The conclusions and suggestions made by Miss Montag are radical departures from the 75-year-old traditional pattern of nursing education in hospital schools and even from the more recently developed practical nurse training programs. Miss Montag gives weighty and authoritative support for her conclusions. Since there have been no such programs developed, experi-

mentation under carefully controlled conditions is recommended. Miss Montag has recently been appointed to direct such experimentation under a grant given Teachers College, Columbia University for that purpose.

All open-minded persons concerned with providing nursing service to meet community needs and those responsible for preparing persons to provide that service should give the contents of this book careful consideration since it gives one way of attacking the problem of providing more adequate nursing care. The questions raised in such careful consideration may well bring us closer to solving the problems.

VIRGINIA A. JONES, R.N.

## HAWAII DISTRICT NURSES' ASSOCIATION

### Institute on Poliomyelitis Nursing

**Hilo, Hawaii—June 2 & 3, 1952**

"Let's have more workshops!", "More institutes, please", "Interesting!", "Stimulating!", "Let's have more!"

Such were the responses of nurses on the Big Island who attended the institute on Poliomyelitis Nursing held in Hilo on June 2 and 3. The institute was planned and co-sponsored by the Nurses' Association, County of Hawaii, the American Red Cross Nursing Service, and the Hawaii Chapter of the National Foundation for Infantile Paralysis.

Speakers included Dr. Walton Edwards of Tripler Hospital, Dr. J. Warren White of Shriner's Hospital, and Dr. Walter Quisenberry, chief of the Bureau of Preventive Medicine, Department of Health. Demonstrations of nursing procedures were carried out by Miss Mildred Asato and Miss Veronica McDermott. Mrs. Sybil Voorhies discussed and demonstrated the role of the physiotherapist and her relation to other members of the professional team.

It was a lot to pack into two days, but the response certainly proved that nurses on Hawaii are willing to sacrifice time and effort to keep abreast of nursing knowledge. Answers given to an evaluation questionnaire showed that nurses on Hawaii (and presumably everywhere) are especially appreciative of:

1. good speakers who present material in a down to earth fashion
2. good planning—a minimum of wasted time
3. practical demonstrations of nursing procedures
4. good films

Many of the nurses gave suggestions for future institutes and we hope we will have another in the not too distant future.

### Annual Meeting—June 24, 1952

Members of the Nurses' Association, County of Hawaii, enjoyed dinner at the Lanai on the occasion of their annual meeting held in Hilo on Tuesday, June 24, 1952.

Annual reports were given by the officers and committee chairmen.

New officers elected at this meeting were:

*President:* Mrs. Elizabeth Stillman
*2nd Vice-President:* Mrs. Hazel Flagg
*Treasurer:* Miss Mary E. Stanley
*Directors:* Mrs. Hatsumi Ishikawa, Mrs. Chiyo Meyers

Members of the association presented both Mrs. Stillman and Mrs. Mae Marcallino, outgoing president, with orchid corsages. The members present gave Mrs. Marcallino a standing vote of thanks for the hard work she has done for the association during her term of office.

### Personal Notes

Miss Florence Terry, R.N., Puumaile Hospital, Hilo, traveled to Honolulu and Maui in June. She is a member of the Gleemen of Hawaii and took part in the concerts given by that group.

Mrs. Mauricio Valero, R.N., Hilo Memorial Hospital, left in June for Cook County Hospital in Chicago, Illinois, where she will spend three months studying Pediatric nursing.

Mrs. Hilda Akana and Mrs. Emma Lau, Public Health Nurses, attended the workshop on Family Relations at the University of Hawaii in Honolulu from June 23 through July 11, 1952.

Miss Lucy Packard, Public Health Nurse from Kau district, has been transferred to Molokai where she will replace Miss Bernadette Couture. Miss Couture, just back from a visit to the mainland, will fill the district left vacant by Miss Packard.

Miss Reiko Uechi of Kona County Hospital has resigned and will live in Honolulu.

Miss Rose Hee, formerly Assistant Supervisor of Public Health Nurses on Hawaii, and now Supervising Public Health Nurse on Kauai, spent a week in July renewing old acquaintances on Hawaii and visiting Madam Pele. Miss Hee was accompanied by Miss Myrna Campbell, Public Health Nurse, also of Kauai.

Mrs. Kiyoko Ota, R.N., educational director of Hilo Memorial Hospital, resigned on June 14, 1952. She will be replaced by Miss Miriam Kemmerer, R.N., of Washington, D. C. This will be Miss Kemmerer's second "tour of duty" in Hilo; she was here in 1950.

Miss Barbara Cates, R.N., of San Francisco, California, joined the staff of the Hilo Memorial Hospital on June 8, 1952. Miss Cates comes to Hilo from Sacramento, California.

Miss Michie Morishita, R.N., of the Kona Hospital, was married to Gilbert Fukumitsu on July 12, 1952. They will live in Kona.

Miss Caroline Morita, R.N., of Hilo Memorial Hospital, became the bride of Bunichi Usagawa on May 10, 1952.

## ANNUAL MEETINGS

October 27, 28 and 29 are the dates for the twenty-first annual meeting of Nurses' Association, Territory of Hawaii; and the fifth annual meeting of the Hawaii Chapter, National League of Nursing Education at the Mabel Smyth Building, Honolulu, T. H.

"Human Relations in Nursing" will be the convention theme.

The Advisory Council will meet at 7:30 on Monday morning, with the opening business meeting of the House of Delegates at 9:15. The afternoon will be devoted to a panel on mental hygiene with Mrs. Cosette Mulder, Executive Secretary, Mental Hygiene Society, as moderator. There will be an hour for section meetings (more later if needed) and a dinner in the evening will honor Miss Ella Best, Executive Secretary, American Nurses' Association.



MISS ELLA BEST, R.N.
Executive Secretary
American Nurses' Association

Tuesday, Miss Best will speak on "Your Place in Nursing Today." The League of Nursing Education is planning two nursing procedure demonstrations and an interesting afternoon program (still to be announced). In the evening there will be a meeting on economic security with Miss Ella Best as speaker.

Wednesday morning will be fully occupied with a business meeting of the House of Delegates. In the afternoon there will be a brief meeting of the Advisory Council followed by excursions to interesting institutions. Miss Best will meet with the Interschool Council of the Hawaii Student Nurses' Association.

There will be music by students; a nurses' uniform parade; Hawaiian music, food and dresses; movies; and surprise numbers by members of our own association. There will be serious discussion with time for gayety and laughter. Let's make this the biggest and best yet!

## ALTERNATE DELEGATE

When your Biennial delegates learned that Miss Annette Hammersland, who has been employed at Hilo Sugar Company, was attending the A.N.A. sessions, they held a quick caucus. As a result Miss Hammersland was registered as an official delegate (alternate for Mrs. Alice Scott) for Hawaii.

## SALARY RECLASSIFICATION

The following letter was sent by the Nurses' Association, Territory of Hawaii Board of Directors, August 16, 1952, to Mr. Thomas B. Vance, Director of Institutions and to Dr. Charles L. Wilbar, President, Board of Health.

"The recommended allocation of classes to pay grades by the Salary Standardization Board of Hawaii was brought to the attention of the Board of the Nurses' Association, Territory of Hawaii by Miss Dorothy Benson, Miss Alison MacBride, and Mrs. Esther K. Flores, who have served on the Nursing Advisory Committee.

"After considering the responsibilities inherent in nursing functions as compared to those of other classes, specifically domestic and custodial personnel, who have been placed in the same pay grades as aides and nurses, the Board wishes to make the following recommendations:

1. That the number of steps should be increased.

2. That the allocation of hospital personnel be changed as follows:

a. Hospital attendant from GS 1 to GS 2
b. Practical nurse from GS 2 to GS 3
c. Staff nurse from GS 4 to GS 5
d. Senior staff nurse be combined with head nurse in GS 7
e. Supervising nurse from GS 7 to GS 8
f. Chief nurse and Director of nursing 1 from GS 8 to GS 10
g. Assistant director of nursing from GS 9 to GS 10
h. Director of nursing 11 from GS 10 to GS 11
i. Director of nursing 111 from GS 11 to GS 12
j. Cadet public health nurse from GS 3 to GS 5
k. Public health nurse from GS 5 to GS 6

"If further explanation of these recommendations is desired, please call one of the above mentioned committee members or Sister Mary Albert, Director of Nursing at St. Francis Hospital and Acting President of the Nurses' Association.

"Your careful consideration of the above will be appreciated."

## BORIC ACID

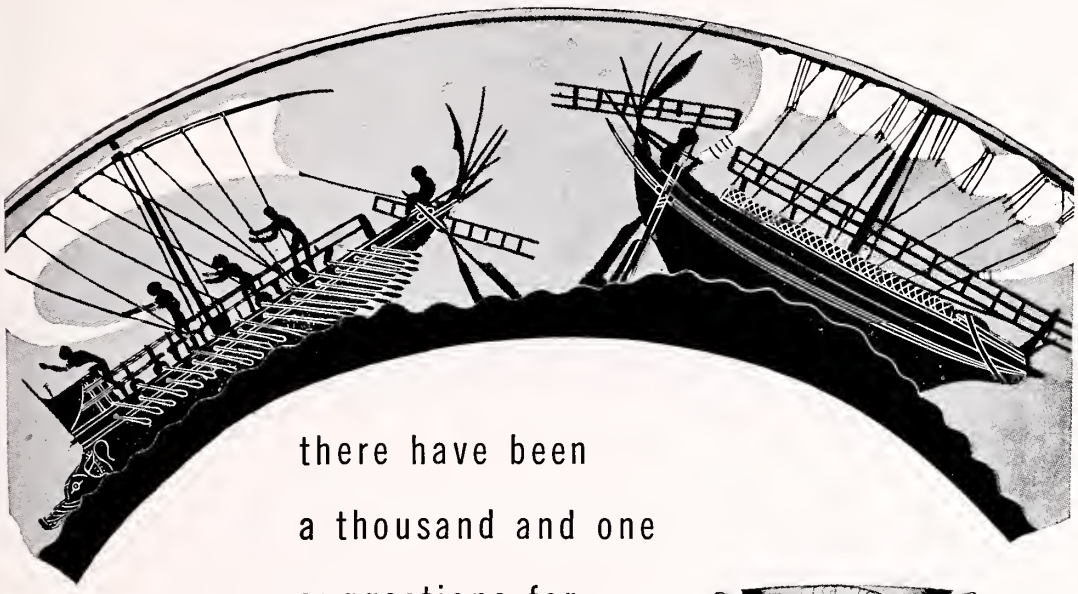
The following excerpt comes from a mainland medical newsletter "Good Health for Wyoming" edited by Franklin D. Yoder, date-line April 23, 1952: "Dr. Lawrence J. Cohen, Cheyenne pediatrician, presented an interesting case to the staff of the Laramie County Memorial Hospital last week. It was an infant death due to boric acid poisoning from absorption through a skin lesion.

"Dr. Cohen presented a very effective case against the use of boric acid, stating that solutions of it used in a nursery were found to be supporting a growth of staphylococci. This along with the opinions he presented that it is of very doubtful therapeutic value, makes one wonder why it has been so widely used in the past. Perhaps now is a good time to take stock and determine how much it should be used if any in the practice of medicine."

This, food for thought, stimulated discussion in the Health Department where it was recognized that with boric acid there could be absorption to toxic levels through the skin, that it could be dangerous, that other drugs might more safely and effectively be used, and that in pediatric practice the bottle should always be labeled "poison."

While use and therapeutic value of boric acid is primarily a problem for medical re-evaluation, nurses may well be aware of its dangerous potentialities and more alert to discourage its presently rather widespread unprescribed use.

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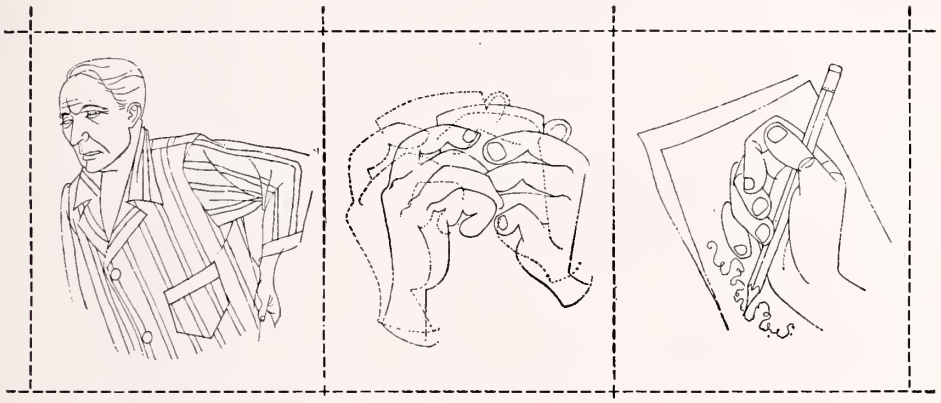
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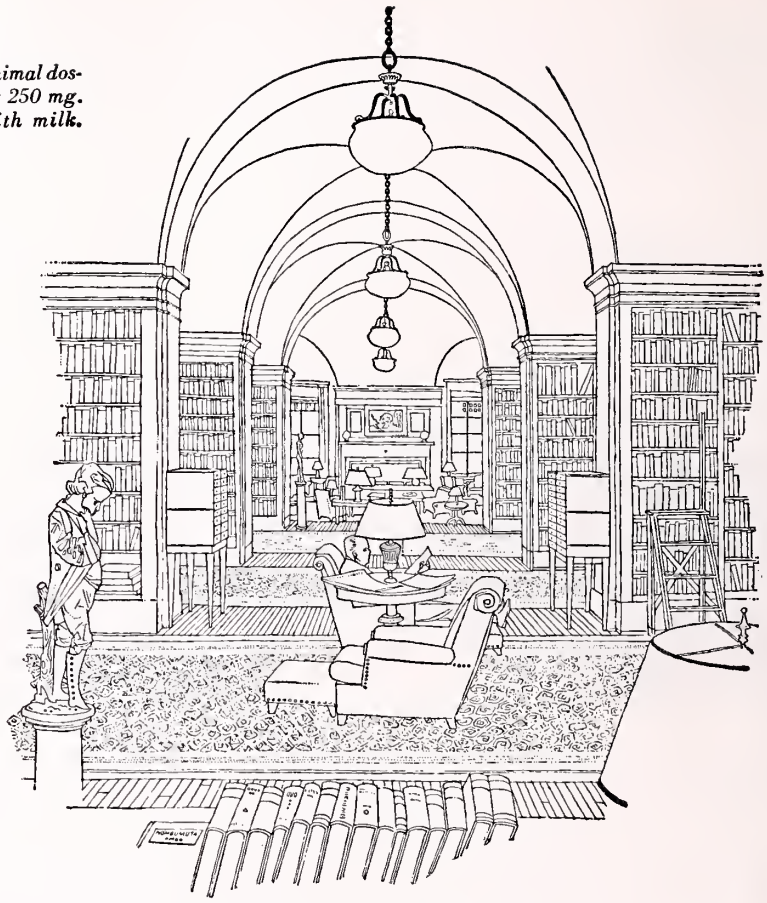
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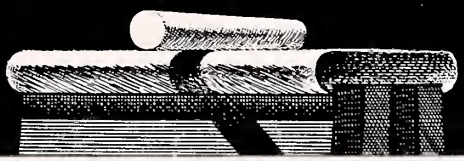
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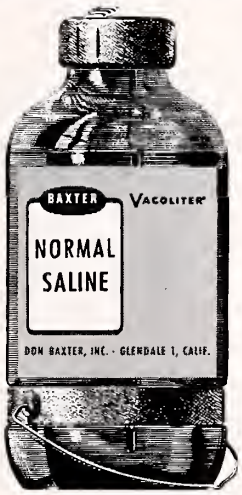


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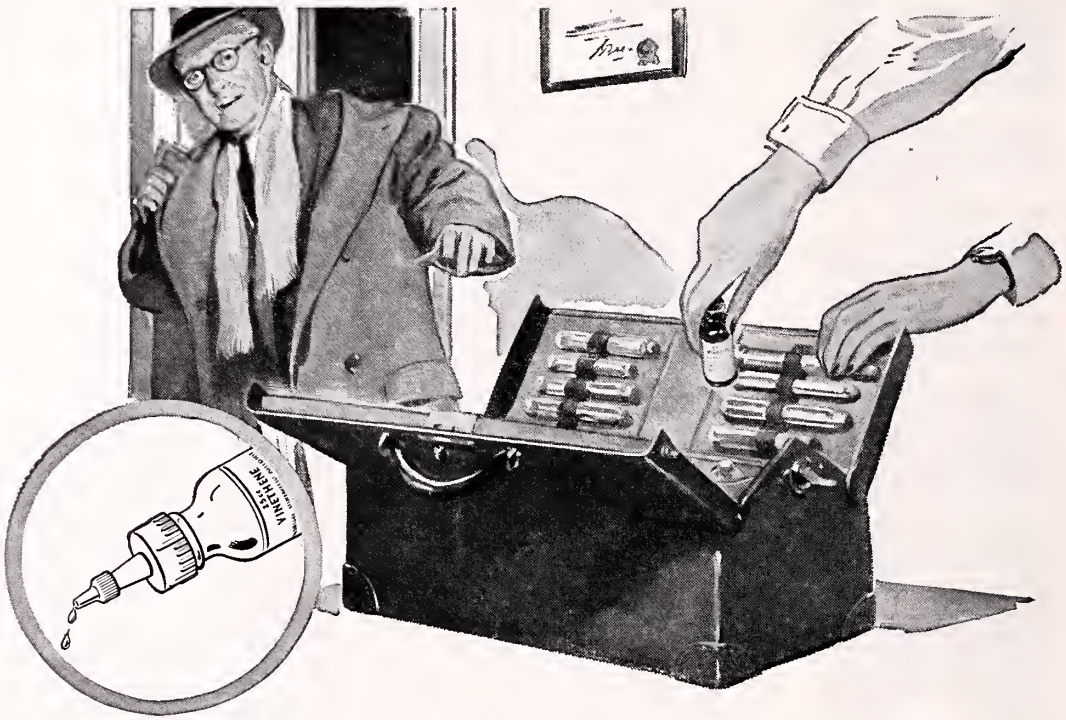
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1. Freeman, B. S., and Young, T. K., Jr.: *Arch. Surg.*, 61:1145, Dec., 1950.

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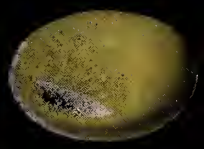
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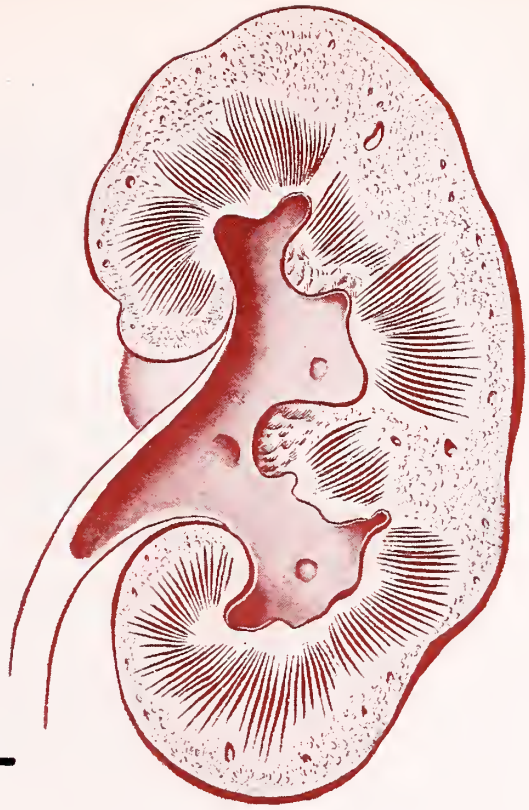
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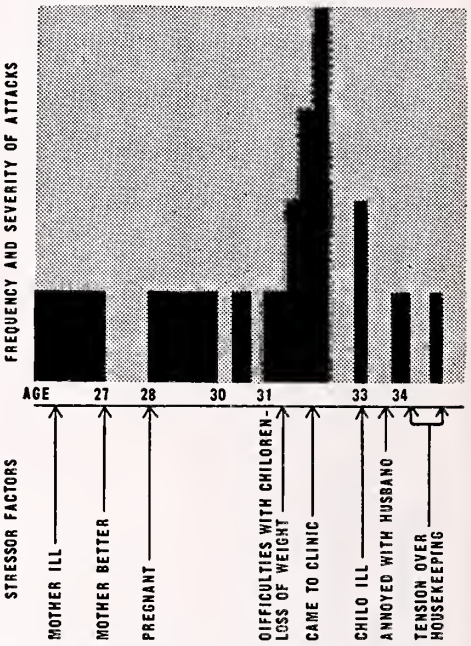


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After: Relationship Between Life Stress And Symptoms — Stevenson, I.: G.P. *4*: 67 (Dec.) 1951

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[1] *Cleghorn, R. A. and Graham, B. F.: Recent Progress in Hormone Research, Vol. IV, New York, Academic Press, Inc., 1949, p. 323.*

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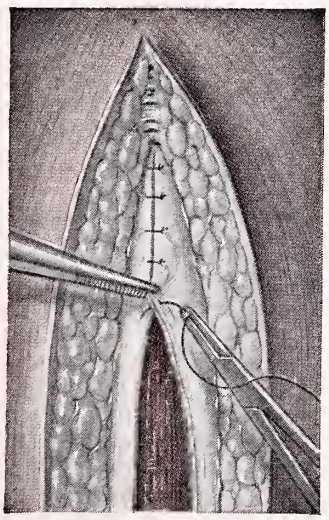
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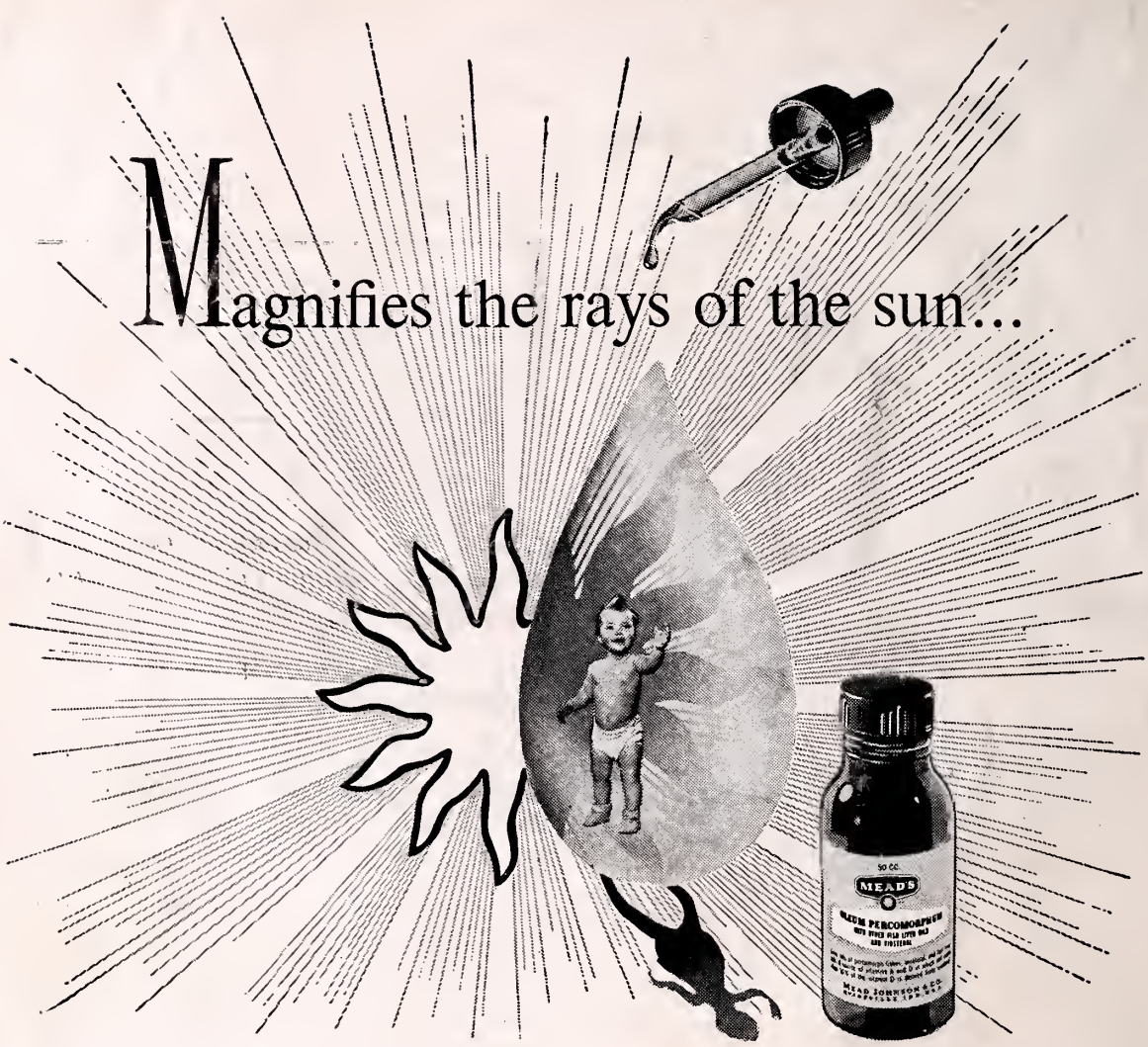
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1. Michael, N.: Ohio State M. J. *48*:42, 1952.
2. Carter, S., in Conn, H. F.: Current Therapy 1952, Philadelphia, W. B. Saunders Company, p. 610.
3. Lennox, W. G., in Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine ed. 8, Philadelphia, W. B. Saunders Company, 1951, p. 1379.
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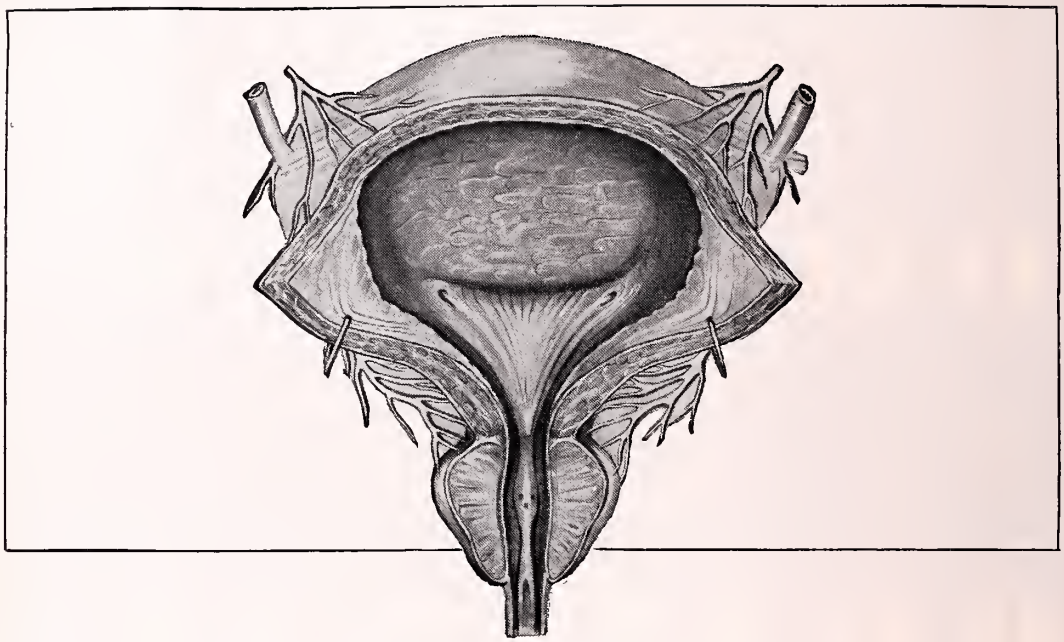
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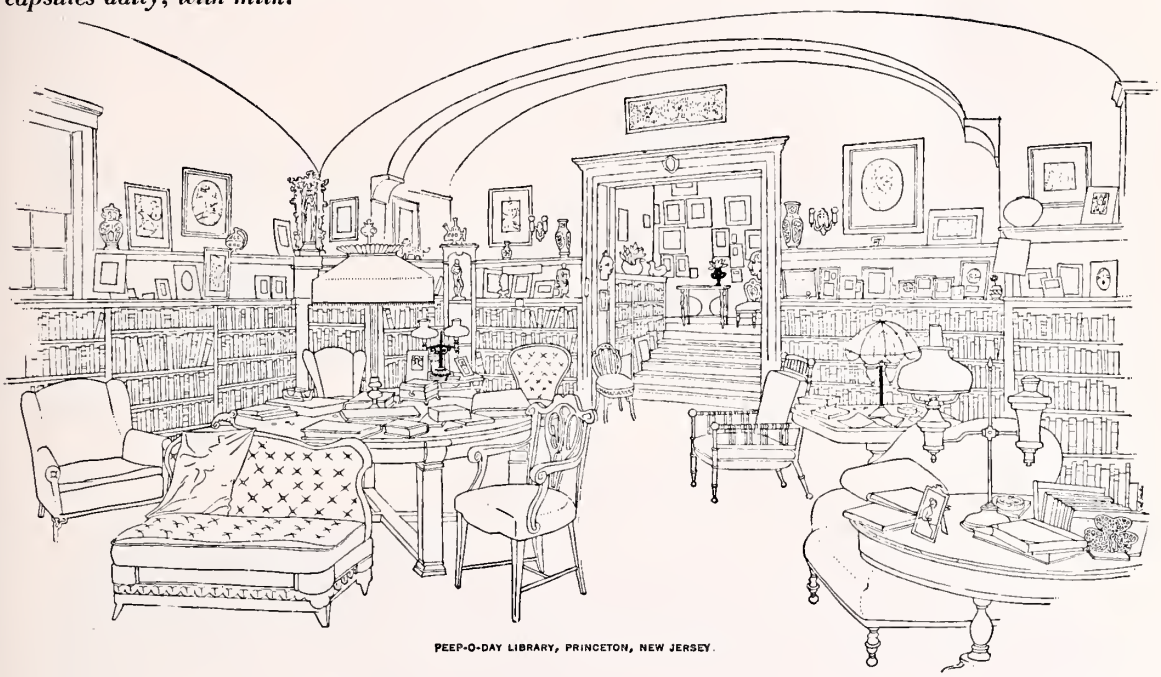


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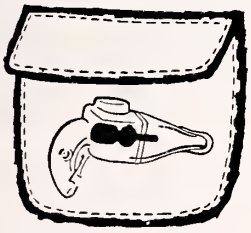
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1. Kaufman, R., and Farmer, L. (1951), Norisodrine by Aerohalor in Asthma, Ann. Allergy, 9:89, January-February.
2. Swartz, H. (1950), Norisodrine Sulphate (25 Per Cent) Dust Inhalation in Severe Asthma, Ann. Allergy, 8:488, July-August.
3. Krasno, L., Grossman, M., and Ivy, A. (1949), The Inhalation of 1-(3′,4′-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March.

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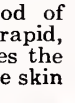



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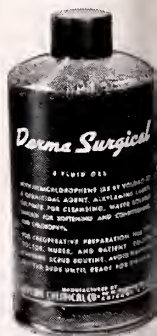
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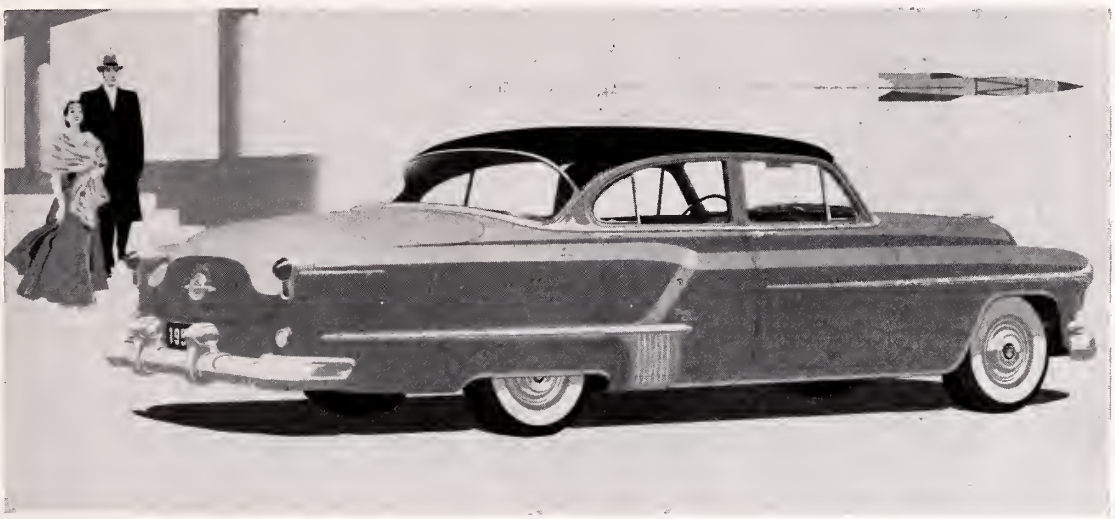
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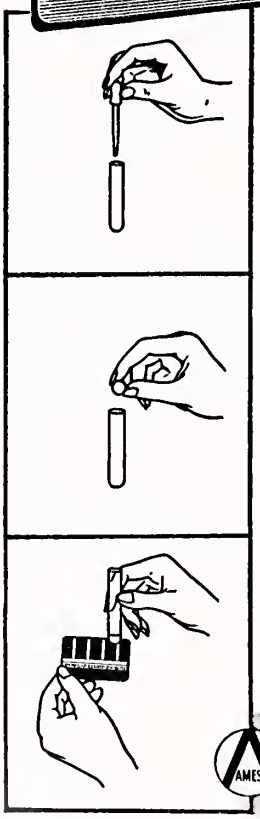
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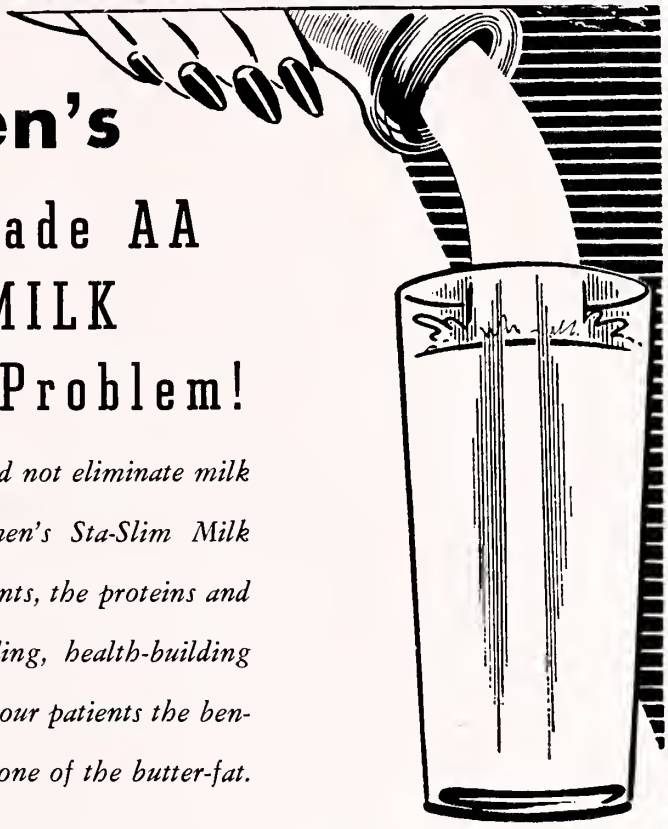
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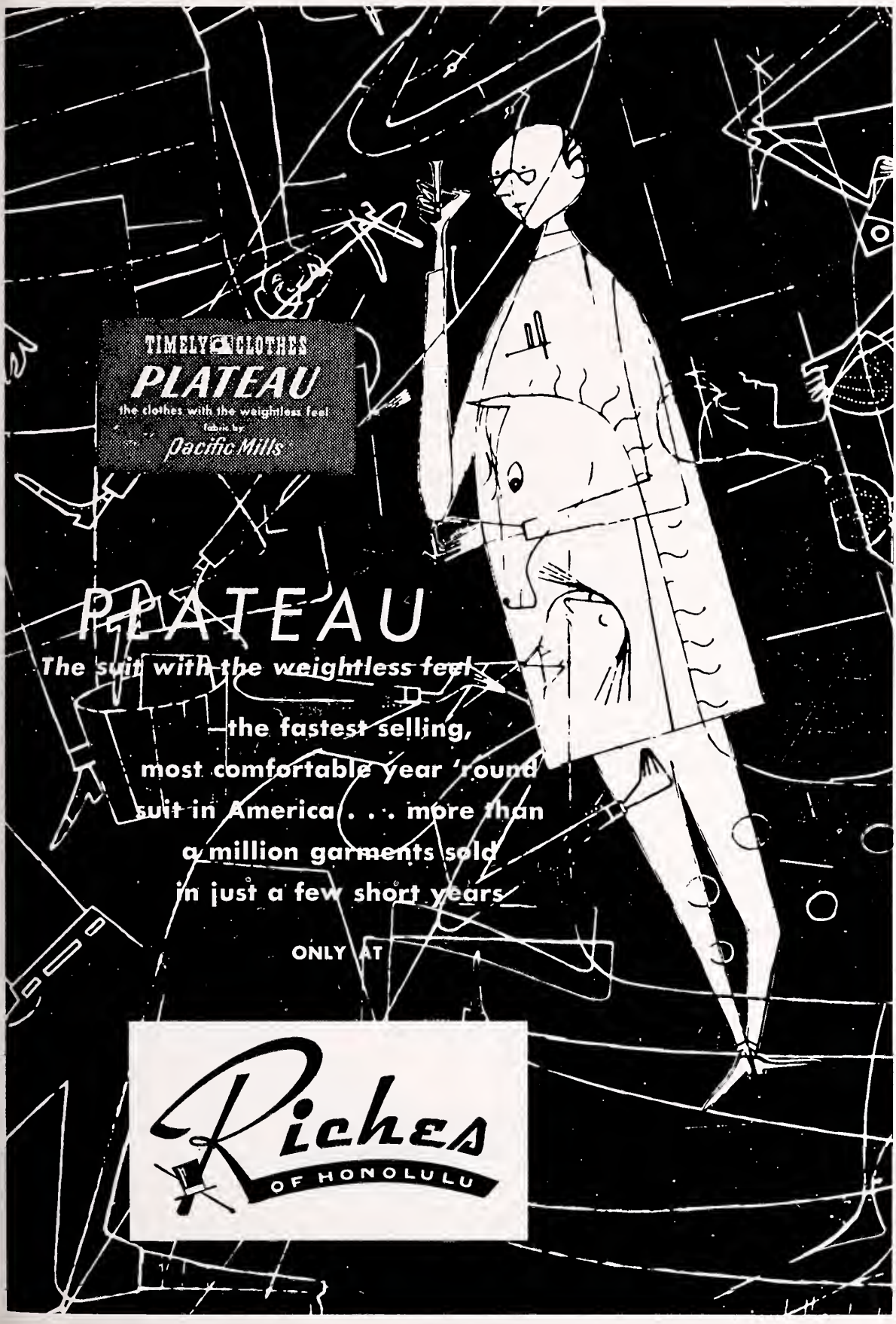
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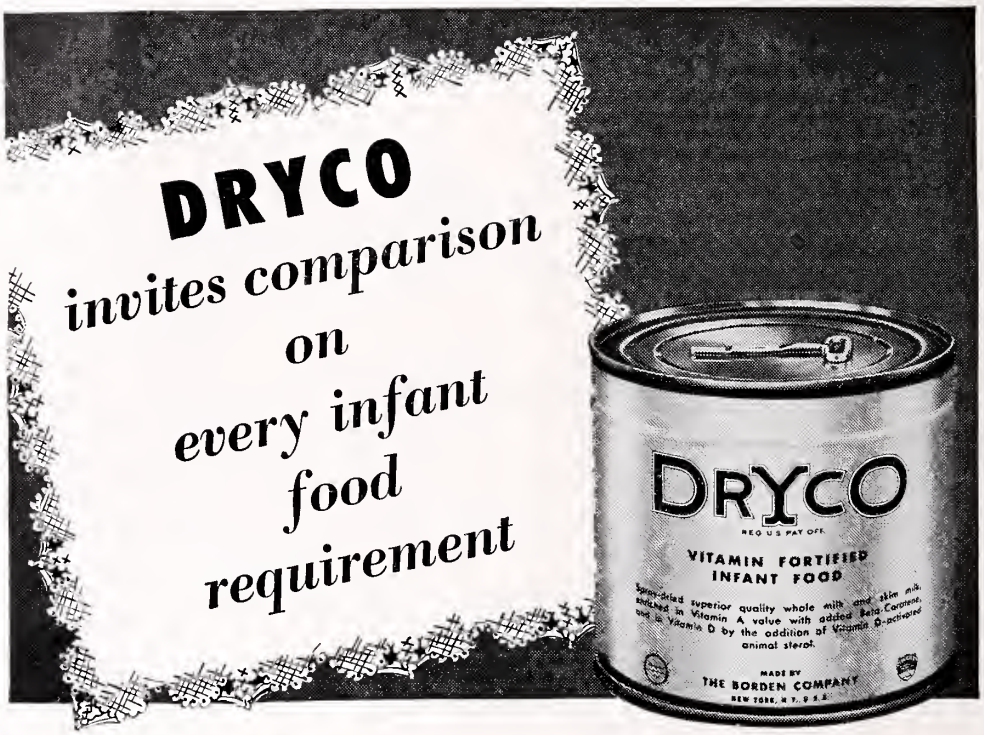


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# The Mismanagement of Chronic Abdominopelvic Pain

R. T. WEST, M.D.
HONOLULU

IT is unfortunate that so many patients, and far too many doctors, are imbued with the idea that the only solution for many of the ailments of women, especially for chronic pain and discomfort in the abdominopelvic region, is surgery. Because of this, a large number of unwise and unnecessary laparotomies are being performed, too many of them in the abdomens of unfortunate women who happen to complain of chronic low abdominal pain.



DR. WEST

We will have to admit that the opening up of the field of surgery some fifty-five years ago furnished us the key with which we were able to unlock the caverns of ignorance of living pathology, and that modern surgery has been one of the chief factors in relieving suffering and in the saving of lives. However, during this past half century many changes have taken place in the entire field of medicine and there is no reason why we should continue to keep surgery on a plane far above its present proper level in the treatment of some of the ills of womankind. We should continue to evolve and it is time that we put surgery in its proper but very necessary place, for not only do many of these ill-advised, improperly evaluated, ailing women receive no benefit from the surgical procedures, but a goodly number of them are actually made worse.[1]

We will all agree that women with abdominopelvic pain can be most baffling and that a keen insight and considerable experience and time are required in order to make a proper interpretation of such cases. We all know that pain in itself does not necessarily mean organic disease—very few headaches are treated with craniotomies, and we accept the fact that severe and sometimes even prostrating dysmenorrhea can have no definite visceral lesion as a causative factor. Why, then, do so many doctors feel that they must resort to surgery (too often the initial therapeutic attempt) in the treatment of women with chronic abdominopelvic pain? The only answer, it seems to me, is that we are definitely in a rut—a rut from which only too few are trying to extricate themselves, chiefly because it is too often much more profitable for the doctor not to be thorough.[2]

## A Typical Case

Let us take a quick glance at a typical case of a woman who complains of chronic abdominopelvic pain. When a female patient presents such a complaint, it is the usual tendency for the doctor to feel that his fingers will quickly detect the underlying pathologic cause, and so only a very short history is taken, a urinalysis ordered, and an abdominopelvic examination done. The significant findings are often inconsequential. Probably there is slight tenderness in both adnexae, some discomfort on movement of the cervix, and most often tenderness in both lower abdominal quadrants, especially around and below McBurney's point. The urinalysis is not significant. The doctor too often is disappointed in these indefinite findings. He would have been delighted to have found an adnexal or uterine mass, even if it was only a small one. However, since he is stumped without any definite pathological findings, and feeling that he must impress the patient with his diagnostic acumen, he explains to her that her trouble is no doubt due to chronic appendicitis. Following such a diagnosis, it does not take long for both parties to agree that it would be best to have the appendix removed, for it is a known fact that it takes much more time and self-confidence to advise a woman with chronic abdominopelvic pain not to be operated upon than it does to convince her that she needs surgery. And along this line, I would like to state emphatically that I feel there is no more unscrupulous and unprincipled person than a doctor who intimates that he should operate in order to make sure her trouble is not cancer, when he knows full well that that is only the remotest of possibilities.

At this point I would like to interject a remark made by Gordon,[3] who wrote that "A typical appendix incision does much less harm than the midline approach of so many operators with consistent mental reservations, since it makes resection of both ovaries, and round ligament suspension of the uterus, difficult or impossible."

Well, to get on with the story, she has her appendectomy. True, it was not inflamed—after all the diagnosis was chronic, not acute appendicitis. So with this rationalization the surgeon closes the abdomen and the case.

After surgery, the patient improves—for a short time—but only too soon do her symptoms recur. With the

Read before the sixty-second annual meeting of the Hawaii Territorial Medical Association, May 3, 1952.

[1] Atlee, H. B.: Chronic Right-Sided Pain in Women, Canad. Med. Ass'n. J. 53:122 (Aug.) 1945.

[2] Bennett, A. E.: Faulty Management of Psychiatric Syndromes Simulating Organic Disease, J.A.M.A. 130: 1203 (Apr. 27) 1946.

[3] Gordon, C. A.: Pelvic and Abdominal Pain in Women, Rev. of Gastroenterology, 12:353 (Sept.-Oct.) 1945.

inexplicable return of her pain, the doctor, after another fruitless but not too thorough search for a definite causative factor, finally decides and convinces the patient that her trouble is in her female organs and that the only hope for her is another operation. This time the surgeon has a fair choice of a number of meddling procedures which he might perform. The ovary might be "scraped," or even removed if there is a large enough corpus luteal cyst present; the uterus might be suspended by any number of definite or modified procedures, and the tubes can be dealt with as the mood and exposure permit. Anyway, something is removed, since this is very necessary for its psychotherapeutic effect on both surgeon and patient.

Again, the patient improves. The rest in the hospital, the attention from friends and family, the beautiful sweet-smelling flowers, the removal of some emotional and physical strain and stress of living have all helped tremendously. This time the patient remains well—at least long enough to pay her bill—and then she slumps into her usual difficulties.

So the tragedy is repeated; only this time it is with a diagnosis of adhesions—and naturally it is the patient's fault. The sad news is broken to her and she is left to decide between probably enduring the discomfort the rest of her life or having her doctor go into her belly again and take care of things. Still full of faith and feminine hope, she acquiesces.

At the time of this third operation, nothing very pathological is found, but it seems that this lack of findings is the signal for the removal of her uterus along with the remaining ovarian tissue. The logic is that since her discomfort is in her pelvis, the contents of the pelvis must be the source of her trouble. Postoperatively, it is finally realized that this was just the thing that was needed to trip her over the emotional cliff. If she was a little perplexed when she was first seen, she is now really confused. She is far from being cured, because no definitive treatment has been carried out; instead, her condition is worse because of the removal of innocent pelvic organs.

About this time even the most confirmed operator wishes he had never seen this patient and questions the much publicized healing prowess of the renowned scalpel. He finds himself at the end of his therapeutic rope and grabs on to the nearest internist or psychiatrist for help. He obviously refers this patient to them as a neurasthenic chiefly because he has failed to effect a cure by surgery. The patient would have been better off if he had done this at the beginning; but by this time, unless she happens to be passed on to a patient, understanding and experienced physician, her chances of being salvaged are almost nil.

Perhaps some of you think this case history has been exaggerated. However, think back and I am sure many of you will remember similar cases. The fact that most of the cases brought to mind were under the care of some other doctor only proves that many patients with chronic abdominopelvic pain whom you think you have cured have really gone elsewhere. Ask yourself these questions: In how many of your appendectomies in women did you find it not to be the source of the trouble? In how many of your laparotomies do you carry out unnecessary surgery to justify opening the abdomen? How often do you advise surgery for a small cystic ovary or an indefinite mass after one pelvic examination? How often do you make a diagnosis of postoperative adhesions without thoroughly investigating the case? How often do you question your female patients about their emotional life?

I maintain that in these days of sulfa and antibiotic therapy, organic pathology plays a very unimportant role in the over-all etiology of chronic pelvic pain. There are several conditions, or supposed conditions, which are traditionally diagnosed as being the cause of chronic abdominopelvic pain, but which rarely are. The most common are: chronic appendicitis, postoperative adhesions, ovarian cysts and retrodisplaced uteri.

### Chronic Appendicitis

It seems strange that most good surgeons are quite definite about the non-existence of chronic appendicitis, yet it is for this one condition that a large number of laparotomies are done. It must be more than just a coincidence that one of the most constant findings of a gynecologist in cases of chronic abdominopelvic pain is an appendectomy scar. Some surgeons just do not visualize anything except organic pathology as the cause of chronic right lower quadrant pain. I believe it is about time we shied away from the diagnosis of chronic appendicitis. More thorough investigation, more time spent in talking to the patient, and more understanding of the patient as an individual will make us realize that the majority of cases of right lower quadrant pain, chronic in nature, have a functional rather than an organic background.[4]

### Postoperative Adhesions

Next, why do so many physicians persist in blaming postoperative adhesions as the cause of chronic lower abdominal pain when we know there is no substantiated evidence to bear this out? We should remember that adhesions cause pain only when there is obstruction or traction, and that adhesions between tube and ovary, uterus and ovary, uterus and gut, and gut to gut do not cause pain.[3] The lysis of adhesions not causing traction or obstruction cannot be expected to relieve the abdominal symptoms of which the patient complains. Here, again, we should make further clinical investigations before considering a diagnosis of postoperative adhesions, especially before subjecting a woman to another abdominal operation.

[4] Mengert, W. F.: Referred Pelvic Pain, South. Med. J. 36:256 (Apr.) 1943.

### Ovarian "Cysts"

Now a few words about the most mistreated organ in the female, the ovary. I believe that many ovaries would be spared if the operating surgeon would think of them as female testicles. Here are two things to remember about ovaries: (1) normal ovaries are as tender to pressure as are the male gonads; (2) ovarian cysts cause no pain by their internal pressure because there is no peritoneum covering the ovary and therefore no pain sensory pathways to that organ.[5] We all know of cases where enormous ovarian cysts or tumors have been present for years without causing pain. Even non-invasive cancer of the ovary causes no pain. Why, then, are so many women with chronic abdominopelvic pain advised to have tender and slightly enlarged ovaries removed? The tenderness, as noted, is quite often very normal and the enlargement is most often due to a ripe Graafian follicle or corpus luteum cyst which may in itself be as large as, or larger than, the rest of the ovary. It is unfortunate that so many surgeons, on finding a normal appendix, remove an ovary because it happens to contain many large physiological ripe Graafian follicles, and then call it a cystic ovary, feeling satisfied that it was the cause of the right lower quadrant pain. Such poor surgical judgment should be classified in its proper category as mayhem. Strangely enough, in spite of all the miseries attributed to the unfortunate ovary by both doctor and patient, a diseased tube or an infected cervix is much more commonly the cause of pelvic pain.

### Retrodisplaced Uteri

Attributing chronic abdominopelvic pain to a retrodisplaced uterus is definitely a hangover from the days when women went to doctors for vaginal examinations only when they were having pelvic symptoms. In other words, it was not realized that the majority of women with retrodisplaced uteri were symptomless and remained symptomless. The multiplicity of cures or operations advocated for the treatment of this condition and its supposed symptoms should have made us realize earlier that a "tipped womb" had nothing whatever to do with the symptoms.

In spite of this available knowledge, however, uteri continue to be suspended for symptoms such as backache, fatigue, irritability, sterility, dysmenorrhea, pelvic pain, lower abdominal pain, dyspareunia, etc. The fact remains that a retrodisplaced uterus very rarely causes these symptoms. No doubt, many will disagree with this latter statement, but I feel that as time passes, more and more doctors will fall into line with this conservative type of thinking.

For instance, Graves' textbook of gynecology, written in 1916, states, ". . . there can be no doubt that the great majority of women with retroversion suffer in some way from the condition." And he goes on to say, "It is the commonest occurrence to see active, athletic, good tempered women after several childbirths become nervous, irritable, unreasonable, discontented, easily exhausted, and apparently completely changed, both nervously and physically, as a result of the constant pelvic discomfort and weakness from retroversion. . . ." With all due respect to this great gynecologist, he must have had very poor insight into a woman's emotional problems, her anxieties, tensions, fears, etc. On the other hand, Kelly in his textbook written in 1928, twelve years later, says, "This retrodisplacement is also important as it looms up large in the minds of many women as well as of our general practitioners, still lingering as the one plausible explanation of a woman's backache, dysmenorrhea, constipation and general malaise." Janey, in his medical gynecology written seven years ago, says, "Retroflexion and retrocession . . . of the uterus do not produce symptoms." But he still feels that, "In the acquired retroversions, the incidence of symptoms is about 20 per cent . . . in the congenital . . . about 5 per cent. . . ."

I feel that even his figures are too high. In my gynecologic practice, I rarely use a pessary and almost never suspend a uterus, but I do spend considerable time talking to my patients. In spite of this, I have not found that my patients go around suffering any more than anyone else's. For instance, just last month a patient who had been wearing a pessary for one year came in complaining that she still had backaches. On examination a retroflexed uterus, for which she was being treated, was found, but x-rays revealed an old injury of a vertebral body. If her former physician had realized that a retroflexed uterus rarely produces symptoms, and had gone a little more into his patient's history, I am sure he would have discovered her trouble began soon after she fell out of bed eighteen months previously.

### The Usual Causes

I feel that women who complain of chronic lower abdominal or abdominopelvic pain get pushed around, medically and surgically speaking, much more than any other group of patients, and that this will continue to be the case until we routinely make a more thorough investigation, not only of their physical status but especially of their

[5] McFarlane, K. T.: Pelvic Pain, Canad. Med. Ass'n. J. 55:267 (Sept.) 1946.

emotional life.[6] Anxiety states, chronic tension, marital difficulties, domestic troubles, sexual ignorance, sexual conflicts, chronic sexual stimulation, fear of pregnancy, fear of pelvic disease, fear of pelvic cancer and many other emotional upheavals are the most frequent causes of chronic abdominopelvic pain. These conditions cannot be tested for in the laboratory; the physical findings are only suggestive; the real facts can only be unearthed by a definite investigation of your patient's emotional background. In order to do this, you must first get the confidence of your patient and then probe gently, but determinedly, into her past and present emotional history. When did her symptoms begin? During courtship? After marriage? After pregnancy? Was there some definite change in her pattern of life at the time her symptoms began? If married, how often does she have coitus? Is it satisfactory? Is there associated pain? Fear? Disgust? Does she have an orgasm? Are there any in-law difficulties? Financial difficulties? Social troubles? Religious differences, and so forth?

## Case Report

Mrs. V.H., age 45, had had three operations—appendectomy, uterine suspension, and a bilateral salpingectomy with left oophorectomy—and had just been advised to have her uterus out because of her persisting symptoms of abdominopelvic discomfort. Physical examination revealed the usual generalized pelvic tenderness and tenderness over the entire large bowel. Questioning revealed that she had been unhappy all her married life, her sexual life had always been unpleasant, and at the time I saw her, she was trying to obtain a divorce from her husband who had left her one year ago. She agreed that her symptoms were often initiated or aggravated at times of emotional tension, but that she had always hoped and had been led to believe that surgery would relieve her discomfort. With a better insight into her condition, she has for the past year been getting along very well with occasional use of antispasmodics and mild sedatives. Her parting remark on her last visit was, "Why didn't any of the other ten doctors I have seen ever question me about my family life?" I had no answer.

[6] Miller, W. R.: Psychogenic Factors in Pelvic Pain, J.A.M.A. 134:938 (July 12) 1947.

## Comment

The above case history is neither unusual nor uncommon. Time does not permit my reiterating many other cases. The stories are different but the basic factors—etiology, emotional tension, anxiety, fear, etc.—are always there. This means that the treatment is non-surgical.

Dr. Look, of Winston-Salem, reported that in his referred practice, one-third of the women with pelvic complaints had functional pelvic disease; that is, symptoms were out of proportion to the demonstrable pelvic lesion, or there was no organic lesion present. If this is so, then I would venture to say that in a general or group practice, the incidence would be more on the order of one-half.

## Summary

In treating these patients, there is one prime requisite: they must be thoroughly convinced that their troubles are not serious and that there is no organic basis for the complaints. This necessitates a thorough physical examination and quite often x-rays of the urinary and intestinal tracts and spine. Besides this, time must be spent in digging out the patient's emotional difficulties. This in turn must be followed with an unhurried explanation of the mechanism of her discomfort. To tell a patient it is "all in her mind" is of no therapeutic value, but instead builds up a resentment between the patient and her doctor.

Very few of these cases need a psychiatrist's help; in fact, there is much less psychic trauma if her own doctor follows through with whatever psychotherapy is required. In this present day and age, however, this is easier said than done because too many specialists and more and more general practitioners are losing the ability to treat the patient instead of the disease. We are losing the art of medicine and are becoming mere technicians—especially when it involves treating women with chronic abdominopelvic pain.

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# Diagnostic Problems in Infectious Mononucleosis

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THE diagnosis of infectious mononucleosis presents little difficulty in a patient having pharyngitis, lymphadenopathy, and splenomegaly, in whom there is a lymphocytosis including atypical cells, and in whom there is a significant titer of heterophile antibody agglutination as demonstrated by Paul and Bunnell.[1] Unfortunately these generally accepted criteria are not precise. Clinically the disease occurs in epidemic and endemic forms. Involvement of various organ systems[2] resulting in hepatitis,[3, 4, 5, 6] rashes,[7] pneumonitis,[7, 8] meningitis, encephalitis, peripheral neuropathy,[9] hematuria,[10] diarrhea,[11] thrombocytopenic purpura,[12] and hemolytic reaction[13, 14] often focusses attention primarily to these manifestations thus delaying proper diagnosis. Barker, Capps and Allen,[15] and Litwins and Liebowitz,[16] have reported the presence of atypical lymphocytes during virus infections other than infectious mononucleosis, while Goldthwait and Eliot[17] studied these cells in individuals who, although exposed to probable infectious mononucleosis, were without clinical or other laboratory evidence of this disease. Heterophile antibody agglutination has been absent in as many as 57 per cent of the cases in some reports,[18] while significant titers do occur in the absence of this disease following liver injections, in serum sickness, in hematologic dyscrasias, in tuberculosis, and in other bacterial infections.[19] In practice, cases with findings strongly suggestive of infectious mononucleosis are encountered who do not meet the specific requirements for diagnosis. These incomplete cases present perplexing problems to the busy clinician; inclusion of them in reports by some and not by other authors may partially explain the wide range of incidence of the various features.



CAPTAIN VAN AVERY

The records of 74 individuals with a discharge diagnosis of infectious mononucleosis who were hospitalized at Tripler Army Hospital between January 1950 and March 1952 have been reviewed by us. Twenty-one cases were excluded from the study because of insufficient evidence, or evidence of other infection. Thirty-nine cases were considered proven on the basis of the presence of two or more of the diagnostic criteria. In 14 cases, the diagnosis was probable, but not proven. The age range was similar; over 75 per cent of both groups were between 18 and 25 years. Two of the 39 proven casese were female as was 1 of the probable cases. Tables 1, 2, and 3 compare the incidence of the symptoms, physical findings and results of laboratory studies in these groups with reports in the literature.

From the Medical Service, Tripler Army Hospital, APO 438, San Francisco, Calif.

Read before the sixty-second annual meeting of the Hawaii Territorial Medical Association, May 3, 1952.

[1] Paul, J. R., and Bunnell, W. W.: The Presence of Heterophile Antibodies in Infectious Mononucleosis, Am. Jour. Med. Sci. 183:90 (Jan.) 1932.

[2] Bernstein, A.: Infectious Mononucleosis, Medicine 19:85 (May) 1940.

[3] Gall, E. A.: Serum Phosphatase and Other Tests of Liver Function in Infectious Mononucleosis, Am. Jour. Clin. Path. 17:529 (July) 1947.

[4] Evans, A. S.: Liver Involvement in Infectious Mononucleosis, Jour. Clin. Invest. 27:106 (Jan.) 1948.

[5] Bennett, H. D., Frankel, J. J., Bedinger, P., and Baker, L. A.: Infectious Mononucleosis with Hepatitis, Arch. Int. Med. 86:391 (Sept.) 1950.

[6] Watson, J., Johnson, P., Kahn, J., and Stone, F. M.: Subclinical Infectious Mononucleosis with Hepatitis: Epidemic in a Class of One Hundred Two Medical Students; a Two-Year Study, AMA Arch. Int. Med. 88:618 (Nov.) 1951.

[7] Wechsler, H., Rosenblum, A., and Sill, C.: Infectious Mononucleosis, Report of an Epidemic in an Army Post, Ann. Int. Med. 25:113 and 236 (July and Aug.) 1946.

[8] Ziegler, E. E.: Infectious Mononucleosis, Report of a Fatal Case with Autopsy, Arch. Path. 37:196 (Mar.) 1944.

[9] Bernstein, T. C., and Wolff, H. G.: Involvement of the Nervous System in Infectious Mononucleosis, Ann. Int. Med. 33:1120 (Nov.) 1950.

[10] Thompson, W. T., Jr., and Pitt, C.: Frank Hematuria as a Manifestation of Infectious Mononucleosis, Ann. Int. Med. 33:1274 (Nov.) 1950.

[11] Walker, S. H.: Infectious Mononucleosis Manifested by Diarrhea, Armed Forces Med. Jour. 2:1875 (Dec.) 1951.

[12] Angle, R. M., and Alt, H. L.: Thrombocytopenic Purpura Complicating Infectious Mononucleosis, Report of a Case and Serial Platelet Counts During the Course of Infectious Mononucleosis, Blood 5:499 (May) 1950.

[13] Berte, S. J.: Acute Hemolytic Anemia in Infectious Mononucleosis, N.Y. State Jour. Med. 51:781 (Mar. 15) 1951.

[14] Sawitsky, A., Papps, J. P., and Wiener, L. M.: The Demonstration of Antibodies in Acute Hemolytic Anemia Complicating Infectious Mononucleosis, Am. J. Med. 8:260 (Feb.) 1950.

[15] Barker, M., Capps, R. B., and Allen, F. W.: Acute Infectious Hepatitis, J.A.M.A. 128:997 (Aug. 4) 1945.

[16] Litwins, J., and Leibowitz, S.: Abnormal Lymphocytes in Virus Diseases other than Infectious Mononucleosis, Acta Haemat. 5/4 223 1951; Quoted from Abs. #7092 Int. Med., Sect. 6 of Excerpta Medica 5:1486 (Nov.) 1951.

[17] Goldthwait, D. A., and Eliot, J. W.: Confusing Aspects of Infectious Mononucleosis, Am. J. Med. Sci. 221:264 (Mar.) 1951.

[18] Kaufman, R. E.: Heterophile Antibody Reaction in Infectious Mononucleosis, Ann. Int. Med. 21:230 (Aug.) 1944.

[19] Schultz, L. E.: Heterophile Antibody Titer in Diseases other than Infectious Mononucleosis, Arch. Int. Med. 81:328 (Mar.) 1948.

TABLE 1.—*Symptoms (in Percent).*

| | TRIPLER HOSPITAL | | LITERATURE REFERENCES | | | | | |
|---|---|---|---|---|---|---|---|---|
| | *Proven* | *Probable* | 5 | 20 | 21 | 22 | 23 | 24 |
| Fever | 59 | 64 | 90 | 22 | 34 | 98 | 87 | 56 |
| Sore Throat | 56 | 43 | 50 | 49 | 52 | 31 | 73 | 64 |
| Malaise | 54 | 50 | 20 | 24 | 25 | 34 | 56 | 60 |
| Headache | 44 | 43 | 60 | 24 | 35 | 35 | 24 | 68 |
| Cough | 41 | 21 | .... | 13 | .... | 10 | 22 | .... |
| Nodes | 33 | 29 | 40 | 27 | .... | .... | .... | 24 |
| Chills | 23 | 21 | 60 | .... | 17 | 28 | .... | .... |
| Rash | 8 | 7 | .... | 4 | .... | 17 | .... | .... |
| Stiff Neck | 3 | 7 | .... | .... | 5 | 5 | 3 | 8 |

TABLE 2.—*Physical Findings (in Percent).*

| | TRIPLER HOSPITAL | | LITERATURE REFERENCES | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Proven* | *Probable* | 5 | 7 | 20 | 21 | 22 | 23 | 24 |
| Lymphadenopathy | .... | .... | 88 | .... | 98 | .... | .... | 100 | 96 |
| Cervical | 90 | 93 | .... | .... | .... | 76 | 75 | .... | .... |
| Axillary | 62 | 79 | .... | .... | .... | 46 | 29 | .... | 52 |
| Inguinal | 62 | 71 | .... | .... | .... | 38 | 29 | .... | .... |
| Epitrochlear | 39 | 36 | .... | .... | .... | .... | 9 | .... | .... |
| Pharyngitis | 54 | 19 | 48 | .... | 49 | .... | .... | 43 | .... |
| Tonsillitis | 36 | 14 | .... | .... | 10 | 52 | .... | 46 | .... |
| Hepatomegaly | 26 | 36 | 34 | 17 | 16 | 15 | 27 | .... | .... |
| Splenomegaly | 56 | 57 | 30 | 35 | 35 | 43 | 72 | 25 | 20 |
| Rash | 8 | 21 | .... | 16 | 5 | 8 | 19 | 11 | 20 |
| Jaundice | 3 | 7 | 11 | 6 | 4 | 7 | 5 | 2 | .... |
| Pulmonary | 13 | 14 | .... | 5 | .... | .... | .... | .... | .... |

TABLE 3.—*Laboratory Studies (in Percent).*

| | TRIPLER HOSPITAL | | LITERATURE REFERENCES | | | | |
|---|---|---|---|---|---|---|---|
| | *Proven* | *Probable* | 5 | 3 | 4 | 7 | 24 |
| WBC Below 5,000 | 8 | 7 | .... | 0 | .... | 4 | 12 |
| Above 10,000 | 33 | 7 | .... | 50 | .... | 36 | .... |
| Over 50% Lymphocytes | 95 | 64 | .... | 97 | 68 | 50 | 92 |
| Over 10% Abnormal Lymphs | 62 | 21 | .... | .... | .... | 100 | .... |
| Heterophile Agglutination | 85 | 43 | 90 | 97 | 89 | 62 | 80 |
| Pneumonitis (X-ray) | 5 | 21 | .... | .... | .... | 3 | .... |
| Abnormal Hepatic Function | 31 | 14 | 90 | 94 | 89 | .... | .... |

In general, the incidence of the clinical findings was similar in both our groups, falling into ranges of other reported series. Lymphocytosis, atypical lymphocytes and heterophile antibody agglutination occurred less frequently in the unproven than in the proven group. While there have been reports[6, 17] in which the diagnosis was made on the basis of laboratory evidence with minimal clinical findings, the diagnosis in our unproven group is based primarily on the clinical findings without laboratory substantiation. This suggests that the disease exists in a clinical form which is difficult to recognize because of the borderline or absent confirmatory laboratory studies.

In the proven group there were cases of unusual interest because of other disease entities present at the same time. In one case having heterophile antibody agglutination in titers of 1:6400 and a 70-85 per cent lymphocytosis containing 50 per cent atypical forms, roentgenographic demonstration of a pneumonitis of the left lung was associated with cold agglutination titers of 1:160. These findings were thought to represent a coincidental occurrence of primary atypical pneumonia. In another case whose blood contained 70-80 per cent lymphocytes with up to 32 per cent atypical forms and agglutinated sheep cells in a titer of 800, chancroid and primary lues were diagnosed by bacteriologic and darkfield examination of the exudate from a penile ulcer. Although these cases were somewhat confusing, the diagnosis in each was easily established by laboratory evaluation. The absence of such confirmatory evidence in the cases of the unproven group was of marked concern to the doctor. As will be shown in the following case reports, some of these individuals were acutely ill and the selection of proper therapy was difficult.

[20] Read, J. T., and Helwig, F. C.: Infectious Mononucleosis; An Analysis of Three Hundred Cases with Three Characterized by Rare Hematologic Features, Arch. Int. Med. 75:376 (June) 1945.

[21] Stevens, J. E., Bayrd, E. D., and Heck, F. J.: Infectious Mononucleosis; a Study of 210 Sporadic Cases, Am. J. Med. 11:202 (Aug.) 1951.

[22] Press, J. H., Shlevin, E. L., and Rosen, A. P.: Infectious Mononucleosis; A Study of 96 Cases, Ann. Int. Med. 22:546 (Apr.) 1945.

[23] Kruger, A. L., Wallace, A. W., and Penchansky, S. J.: Infectious Mononucleosis; A Clinical Study of 63 Cases, Ann. Int. Med. 23:915 (Dec.) 1945.

[24] Mitchell, R. H., and Zetzel, L.: Infectious Mononucleosis in the Army, War Medicine 5:356 (June) 1944.

TABLE 4.—*Findings in Five Cases of Probable Infectious Mononucleosis.*

| | | | | | |
|---|---|---|---|---|---|
| Age | 19 | 21 | 21 | 24 | 24 |
| Symptoms | | | | | |
| Sore Throat | + | | | + | + |
| Chill | + | + | + | | |
| Fever | + | + | + | + | + |
| Headache | | + | | + | |
| Findings | | | | | |
| Pharyngitis | + | + | | + | + |
| Nodes—Cervical | + | + | + | + | + |
| Axillary | + | + | + | + | + |
| Epitrochlear | | + | | + | + |
| Inguinal | | + | + | + | + |
| Hepatomegaly | + | + | + | + | |
| Splenomegaly | + | + | + | + | + |
| Laboratory | | | | | |
| 5–10,000 WBC | | + | + | + | |
| 45–51% Lymphocytes | + | + | + | + | + |
| HAA* Not Significant | + | + | + | + | + |
| Normal Liver Function | + | + | + | + | + |
| Hospitalization (WKS) | 2 | 2 | 4 | 2 | 2 |

* Heterophile Antibody Agglutination

Table 4 lists the findings in the most common problem encountered. Each of the five cases presented as a febrile illness with other complaints. Infectious mononucleosis was strongly considered in each because of the adenopathy, splenomegaly and hepatomegaly found on physical examination. The laboratory data failed to substantiate this impression. A differential of 45-51 per cent lymphocytes occurred in all. Atypical cells were noted in only one. In four of the cases there was no heterophile agglutination while in the fifth a rise in titer to 1:28 developed between the first and second weeks. Liver function studies were normal. Of the other possibilities, infectious lymphocytosis is not likely in these cases in view of the splenomegaly, lymphadenopathy and absence of the characteristic blood picture.[25] Beta hemolytic streptococci were grown from the throat of only one individual who had marked generalized lymphadenopathy, splenomegaly, and hepatomegaly with only a mild non-exudative pharyngitis. On symptomatic therapy alone in four cases, the course was benign with loss of symptoms and regression of the findings over the period of hospitalization of 2-4 weeks. One patient received penicillin without effect on the similar benign course.

## Case Reports

CASE 6, a 13-year-old boy, was admitted to the hospital for headache of eight hours duration without other complaint. Two weeks prior to admission, a 3-4 day period of dull substernal pain had subsided spontaneously. Examination showed a temperature of 101° F., pulse 120, and blood pressure 116/60. The lungs were clear. Although the heart was not enlarged, systolic murmurs at the apex and base were noted to vary with changes in position. The tip of the spleen was felt and discrete enlarged lymph nodes were palpable in the cervical, axillary, epitrochlear and inguinal regions. Definite neck rigidity was associated with pain on straight leg raising. The white cell count throughout hospitalization varied between 5,000 and 10,000 with 21-51 per cent lymphocytes, none of which were atypical. A maximum sedimentation rate of 17 was present on the eighth day. Cerebrospinal fluid was normal in appearance and in chemical analysis. Despite the presence of 9 leucocytes per cubic mm., of which 8 were polymorphonuclear, no organisms were seen on smear nor grown by culture of the spinal fluid. Blood cultures on 7 occasions were negative for bacteria. The heterophile antibody agglutination (unabsorbed) was inconstantly positive in titers of 1:100 in the first week and 1:200 in the third week, and was negative in the second and fourth weeks. Liver function studies were normal. Roentgenographic examination of the chest showed normal heart and lungs, but soft tissue studies of the abdomen demonstrated moderate hepatomegaly and splenomegaly. Daily temperature spikes of 101° to 104° F. for two weeks were associated with the changes in the murmurs noted on admission. At no time were petechiae seen. He received only symptomatic treatment and spontaneous recovery occurred.

At the time of admission, the possibility of a central nervous system infection was eliminated by examination of the cerebrospinal fluid. Subacute bacterial endocarditis was considered, but discarded on the basis of the negative blood cultures. Infectious mononucleosis which was considered on the second hospital day was eventually accepted as the proper diagnosis because of the course and spontaneous cure.

CASE 7, a 24-year-old woman, was admitted to the hospital with a five day history of headache, backache, fever and nausea. Two days prior to admission, the presence of albuminuria, hematuria, and pyuria was discovered in the outpatient department. Persistence of these findings led to admission for further evaluation at which time a history of a moderate sore throat four weeks previously was obtained. The significant findings on admission consisted of a temperature of 99° F., bilateral costovertebral angle tenderness and minimal axillary and inguinal lymphadenopathy. The white count was between 5 and 10,000 with 60 per cent mononuclear forms of which 5-11 were atypical cells. Repeat urinalyses and urine cultures were negative. The heterophile antibody showed a rise in absorbed titer from 1:14 to 1:28 during the second week and fell to 1:14 in the third and fourth weeks. Cephalin flocculation, thymol turbidity, icteric index and serum bilirubin were significantly elevated for two to four weeks. During hospitalization, the patient remained afebrile. No hepatic enlargement

[25] Moyer, J. B., and Fisher, G. S.: Acute Infectious Lymphocytosis, Blood 5:668 (July) 1950.

or tenderness could be demonstrated despite the development of jaundice and abnormal liver function studies. Further transient enlargement of the axillary and inguinal lymph nodes occurred.

## Comment

The differentiation of infectious mononucleosis and viral hepatitis is often extremely difficult. Lymph node enlargement, lymphocytosis with atypical forms, and evidence of impaired hepatic function is found in both diseases. Pharyngitis and heterophile antibody agglutination are cited as the main differentiating features.[26, 27] In this one case, it is considered that the consistent transient rise and fall of heterophile antibody agglutinins over the period of two weeks is significant despite failure to reach diagnostic levels.

## Case Report

CASE 8, a 27-year-old physician, was hospitalized with the complaint of fatigue of four days duration. Sore throat and posterior cervical lymphadenopathy were noted on the day of admission. Two weeks before admission he had complained of nausea, headache, stiff neck and fever to 101.6° F. On admission the patient was lethargic with temperature of 98.4° F. Slight injection of the posterior pharynx was present. The posterior cervical and occipital lymph nodes were enlarged with tenderness and the spleen was palpable 2-3 centimeters below the costal margin. Laboratory studies showed 5-10,000 white cells with 50-74 lymphocytes including 12 lymphoblasts, 5-10 prolymphocytes and some atypical cells. Bone marrow examination was normal. Heterophile antibody agglutinations were negative except one titer of 1:16. Transient abnormality of liver function studies occurred. During the five weeks of hospitalization, lethargy was marked and generalized lymph node enlargement occurred. The patient was rehospitalized after one week because of malaise and anorexia. At that time, tenderness with a sense of resistance was found in the right upper quadrant. Hepatitis with abnormal liver function studies persisted for the subsequent three months of hospitalization. During this second hospitalization, the spleen gradually reduced in size and became non-palpable. The generalized lymph node enlargement persisted. The heterophile antibody agglutination titer again was never over 1:14.

During the first hospitalization considerable concern existed over the possibility of leukemia because of the reticuloendotheliosis with immature lymphocytes in the peripheral blood. This was ruled out on the basis of normal bone marrow. Later a prolonged period of subacute hepatitis required further hospitalization. This is of interest because of reports of impaired hepatic function caused by infectious mononucleosis lasting as long as 31 months[5] and its possible contributory effect to the development of cirrhosis.[28] The findings of pharyngeal injection, lymphadenopathy, splenomegaly, lymphocytosis containing abnormal cells, and hepatitis are considered evidence of infectious mononucleosis despite the absence of heterophile antibody agglutination.

## Summary and Conclusion

The records of 53 cases of infectious mononucleosis seen at Tripler Army Hospital were analyzed and divided into two groups. Thirty-nine cases were considered to have a proven diagnosis and in 14 cases the diagnosis was probable. Cases are presented in which the clinical impression could not be completely confirmed by laboratory studies, thus posing diagnostic and therapeutic problems.

Infectious mononucleosis is easily recognized in classical form. It may be diagnosed in a subclinical form by laboratory methods. It is believed on the basis of the present study that this disease may also be characterized by clinical findings in which laboratory confirmation is lacking.

## Discussion

DR. F. L. GILES: — We have had the unusual opportunity of hearing from Captain Van Avery and Colonel Lynn a comprehensive summary of the diagnostic problems which may arise in the diagnosis of infectious mononucleosis. These experiences should be quite valuable to us, since they have been derived from an unusually large number of cases to appear on one service and an unusually good variety of cases to occur in that service.

I should like to emphasize a few points which appear to me to be most important in considering infectious mononucleosis. These are: (1) The diagnosis of infectious mononucleosis is based upon a triad, including reticuloendothelial hyperplasia, consisting of lymph gland enlargement, spleen and liver enlargement; (2) the presence of circulating abnormal lymphocytes; (3) a positive heterophile agglutination. However, as the authors of this paper have stated, it is not necessary to have all of this triad to confirm the diagnosis. Circulating abnormal lymphocytes may occur in infectious hepatitis in the first week or in German measles. The heterophile is a non-specific agglutination test and, as has already been shown, may occur in other conditions, and a negative agglutination test, as has been described, does not exclude infectious mononucleosis.

The diagnosis of infectious mononucleosis is quite important to the clinician because of the necessity of determining the therapeutic possibilities of the disease being observed and also because of the fact that the course of infectious mononucleosis may frequently be very prolonged, and if one is able to inform the patient and his family that such may be the case, he may prevent a great deal of embarrassment on his part. It must be kept in mind that infectious mononucleosis has many different types of manifestations. Some of the unusual manifestations of this condition are: mania, hematuria, conjunctivitis, optic neuritis, fascial and nerve paralysis, encephalitis, meningitis, and radiculitis; recurrences and relapses are certainly not infrequent.

[26] Peterson, R. E.: Hepatic Dysfunction in Infectious Mononucleosis; with Review of the Literature, J. Lab. and Clin. Med. 33:1258 (Oct.) 1948.

[27] Berk, J. E., Shay, H., Ritter, J. A., and Siplet, H.: Infectious Mononucleosis and Infectious Hepatitis: Studies Bearing on Certain Resemblances and Differences, Gastroenterology 11:658 (Nov.) 1948.

[28] Leibowitz, S., and Brody, H.: Cirrhosis of the Liver Following Infectious Mononucleosis, Am. J. Med. 8:675 (May) 1950.

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# Pulmonary Embolism and Infarction

## A Statistical Study

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DURING the past decade considerable interest has been focused on the problem of pulmonary embolism and infarction. Some of the stimulating influences for this interest have been the clinical use of the anti-coagulant drugs as an aid in the treatment of this condition, and a more complete understanding of cardio-pulmonary physiology. This widened scope of interest created a greater desire for the early recognition of conditions which predispose to thrombo-embolic pulmonary complication.



DR. GOTSHALK

Pulmonary emboli usually originate in the veins, or the right auricle or ventricle, and consequently represent only a segment of thrombo-embolic phenomena that confront the clinician. Pulmonary embolism may occur without infarction and infarction may occur without embolism. It is conceivable that a sudden occlusion of the pulmonary artery could cause sudden death before infarction could develop.

There are many factors that favor the formation of a thrombus. The most common are: (1) slowing of the blood stream, which can be initiated by many circumstances; (2) changes in the blood itself that increase its coagulability; (3) changes in temperature such as extreme heat or cold; and (4) injury to the endothelial lining of veins or heart chambers, which normally act as a wettable surface to which platelets do not adhere.

Quick[1] recently suggested that with local damage to the vessel wall, adherence and agglutination of platelets ensues. When these agglutinated platelets undergo lysis, thrombin is produced, and a reticulum is formed which traps cellular elements of blood. As the clot retracts, serum is expressed which is rich in "nascent thrombin." If the circulation is slowed, the high concentration of thrombin induces further clotting. The thrombin is propagated mainly at the tip and in the direction of flow. This results in the long tail to the thrombus. Clot retraction appears to be of great significance in the propagation of a thrombus. In the post-operative cases, particularly when the abdomen has been opened, there is always interference with respiratory movements, and with the patient lying still, there is diminished use of the pumping action of skeletal muscles, particularly in the lower extremities. All of these factors play an important part in the production of venous thrombo-embolic complications.

The pulmonary system has for one of its functions the transfer of blood through the lesser circulation for oxygenation. According to present experimental evidence, there is little or no demonstrable vasomotor activity in this system, in contrast to the systemic circulation where variation of peripheral resistance serves to regulate blood flow.[2] The systemic bronchial arteries supply oxygenated blood to the pulmonary bed through a network, rich in collateral circulation, at a pressure approximately 4 to 6 times as great as that found in the pulmonary artery.[3] This pressure differential insures an adequate supply of arterial blood throughout the circulatory bed and beyond the embolism and thus may prevent infarction. If venous congestion is present, embolism readily results in infarction.[4]

The purpose of this paper is: (1) to study the incidence of pulmonary embolism in a large number of hospitalized cases; (2) to determine the age and sex in which this condition is most frequently found; and (3) to find out the type of case in which the complication of pulmonary embolism is most prevalent.

The material for this statistical study is based on The Queen's Hospital records over a six year period from January 1, 1945 to January 1, 1951. During this period there were 80,144 discharged patients. In this group there were 2,093 deaths, of

Read before the sixty-second annual meeting of the Hawaii Territorial Medical Association, May 2, 1952.

[1] Quick, A. J.: New Concept of Venous Thrombosis, Surg. Gyn. & Obs. 91:296 (Sept.) 1950.

[2] Cournand, A.: Recent Observations of the Pulmonary Circulation, Bull. of N. Y. Acad. of Med. (Jan.) 1947.

[3] Wiggers, C. J.: Physiology of Heart and Disease, Lea & Febiger, Phila., 1944, p. 701.

[4] Hanelin, J. & Eyler, W. R.: Pulmonary Artery Thrombosis Roentgen Manifestations, Radiology 56:689 (May) 1951.

which 1,258 or 61 per cent came to autopsy. In this series no attempt was made to separate medical from surgical or obstetrical cases. This survey has included all cases of pulmonary embolism and infarction that were diagnosed clinically or were discovered at autopsy.

### Incidence

It is difficult to estimate the frequency with which pulmonary embolism and infarction occur in any group of hospitalized patients, since many cases go unrecognized. Also, there is no satisfactory clinical test that will help predict the occurrence of thrombo-embolic phenomena. There are certain roentgen manifestations of pulmonary embolism or pulmonary artery thrombosis that have been described,[4] and it is these findings, together with clinical symptoms, on which we rely to make a diagnosis.

Pulmonary emboli have been demonstrated in 10 per cent of autopsies.[5] In fatal embolism, following surgery, the incidence varies in many large series of cases. Barker, Nygaard, Walters and Priestly report that in 172,888 surgical cases, there were 343 deaths from pulmonary emboli or about 0.20 per cent of the total. Ochsner, DeBakey, DeCamp and DaRocha in 186,279 operations had 106 fatal pulmonary emboli or approximately 0.057 per cent of total. However, the autopsy rate was only 33.9 per cent and they corrected this figure to 0.114 per cent. It is generally estimated that 5 to 7 per cent of all surgical deaths are due to fatal pulmonary embolism or infarction.

The number of cases in our series is too small for comparison but should be presented since this condition is a definite problem in our community. The total number of cases of pulmonary embolism and infarction in this series is 63, of which 40 occurred in fatal cases; or about 0.05 per cent of the total. Table 1 shows a summary of cases of pulmonary embolism.

In this group of 63, 17 went undiagnosed clinically but were discovered at autopsy. Fourteen cases recovered. Of the cases coming to autopsy, 3.2 per cent had pulmonary embolism and infarction.

### Age and Sex

In several series[6, 7, 8, 9, 10, 11, 12] of cases of pulmonary embolism and infarction, reported by other authors, the greatest number occur after forty years of age. In our series this also is true. Table 2 shows the incidence by age and sex.

TABLE 1.—*Analysis of 63 Cases of Pulmonary Embolism.*

| YEAR | NO. OF CASES | DIAG. CLINICALLY | NOT. DIAG. CLINIC | PUL. EMBOLISM AUTOPSY FIND. | DIAG. CLINICALLY & RECOVERED | DIED NO AUTOPSY |
|---|---|---|---|---|---|---|
| 1945 | 8 | 7 | 1 | 4 | 2 | 2 |
| 1946 | 10 | 10 | 0 | 4 | 2 | 4 |
| 1947 | 8 | 6 | 2 | 6 | 2 | 0 |
| 1948 | 13 | 6 | 7 | 9 | 1 | 3 |
| 1949 | 11 | 4 | 7 | 8 | 3 | 0 |
| 1950 | 13 | 13 | 0 | 9 | 4 | 0 |
| Total | 63 | 46 | 17 | 40 | 14 | 9 |

TABLE 2.—*Age and Sex of 63 Cases of Pulmonary Embolism.*

| | ALL CASES | | | FATAL CASES | | | NON-FATAL | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Male* | *Female* | *Total* | *Male* | *Female* | *Total* | *Male* | *Female* | *Total* |
| 0–9 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 10–19 | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 |
| 20–29 | 2 | 3 | 5 | 2 | 1 | 3 | 0 | 2 | 2 |
| 30–39 | 4 | 4 | 8 | 2 | 3 | 5 | 2 | 1 | 3 |
| 40–49 | 4 | 8 | 12 | 2 | 4 | 6 | 2 | 4 | 6 |
| 50–59 | 5 | 5 | 10 | 4 | 4 | 8 | 1 | 1 | 2 |
| 60–69 | 10 | 5 | 15 | 6 | 1 | 7 | 4 | 4 | 8 |
| 70–79 | 3 | 3 | 6 | 2 | 2 | 4 | 1 | 1 | 2 |
| 80–89 | 3 | 2 | 5 | 3 | 2 | 5 | 0 | 0 | 0 |
| 90–99 | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 |
| | 31 | 32 | 63 | 21 | 19 | 40 | 10 | 13 | 23 |

[5] Boyd, Wm.: A Text Book of Pathology, Lea & Febiger, Phila., 1943, p. 83.

[6] Barker, N. W., Nygaard, K. K., Walters, W. & Priestly, J. T.: A Statistical Study of Postoperative Venous Thrombosis and Pulmonary Embolism, Proc. Staff Meet. Mayo Clinic 15:1 (Dec. 4) 1940.

[7] Ochsner, A., DeBakey, M., DeCamp, P. & DaRocha, E.: Thrombo-Embolism, Ann. Surg. 134:405 (Sept.) 1951.

[8] Miller R., Berry, J. B.: Pulmonary Infarction a Frequently Missed Diagnosis, Am. J. Med. Sci. 222:197 (Aug.) 1951.

[9] Kirby, C.: Venous Thrombosis and Pulmonary Embolism, Surg. Clin. of N. Am. 26:1389 (Dec.) 1946.

[10] Lam, C. R. & Hooker, D.: Pulmonary Embolism, Am. J. Surg. 123:221 (Feb.) 1946.

[11] Hampton, A. O., Castleman, B.: Correlation of Postmortem Chest Teleo Roentgenograms with Autopsy Findings, Am. J. Radiol. 43:305 (Mar.) 1940.

[12] Welch, C. E., Faxton, H. H.: Thrombophlebitis and Pulmonary Embolism, J.A.M.A. 117:1502 (Nov. 1) 1941.

In our total of 63 cases 77 per cent were over 40 years of age. In the fatal group 75 per cent were over 40 years of age. The occurrence of pulmonary embolism and infarction in regard to sex will vary with the paper consulted. In many, males predominate.[7, 8, 10] In a large number of cases reviewed by Barker, Nygaard, Walters and Priestly, females predominated.[13] In our series the number of cases of pulmonary embolism was approximately equal in each sex.

### Origin of Pulmonary Embolism

Most authors agree that a high percentage of post surgical pulmonary emboli originate in the deep veins of the legs[11, 12, 18] but in a general series, the points of origin vary considerably. Oschner[7] reported 32 per cent of all thromboemboli and 55 per cent of the fatal pulmonary emboli occurred on the medical service. These deaths were attributed to pulmonary embolism with infarction complicating severe heart disease. Kinsey and White[15] reported the presence of pulmonary infarction in 24 of 50 cases of congestive heart failure studied at autopsy. In our series the site from which the embolism originated can be seen in Table 3.

TABLE 3.—*Antecedent Lesion or Disease in 63 Cases of Pulmonary Embolism.*

| | |
|---|---|
| Following Congestive Heart Failure* | 7 |
| Following Myocardial Infarction* | 18 |
| Following Rheumatic Heart Disease or Sub. Bact. Endocard | 6 |
| Phlebo-thrombosis or Femoral Veins | 7 |
| Associated With Hip Fracture of Pelvis | 6 |
| Associated Pelvic Surgery | 9 |
| Following Surgery of Head and Neck | 5 |
| Following Abdominal (upper) Surgery | 2 |
| Miscellaneous: (a) Carcinoma of Lung (b) Acute Typhoid Fever (c) Amyotrophic Lateral Sclerosis | 3 |
| Total cases | 63 |

* The first two items include auricular fibrillation and disturbances of rhythm often associated with these conditions.

[13] Barker, N. W., Nygaard, K., Walter, W., & Priestly, J. T.: A Statistical Study of Postoperative Venous Thrombosis and Pulmonary Embolism, 11 Predisposing Factors, Proc. Staff Meet. Mayo Clinic 16:1 (Jan. 2) 1941.

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[18] Leithauser, D. J., Saraf, L., Smyka, S., & Sheridan, M.: Prevention of Embolic Complications from Venous Thrombosis after Surgery, J.A.M.A. 147:300 (Sept. 22) 1951.

It is interesting to note that in our study approximately 50 per cent of pulmonary embolisms and infarctions occurred in cardiac cases.

### Discussion

In this small series of cases no attempt has been made to evaluate the symptoms produced by venous thrombosis, or the methods used in the treatment or prevention of this condition. These factors have been amply covered by many authors.[7, 16, 17, 18] However, the statistics presented point out that a definite problem involving pulmonary embolism and infarction does exist in this community.

### Summary

A statistical study covering the incidence, age, sex and origin of pulmonary embolism with infarction over a six year period at Queen's Hospital is reported.

### Discussion

DR. ROGERS LEE HILL: — Dr. Gotshalk has rendered us an invaluable service tonight in presenting this statistical survey on thromboembolism. The infrequency of fatal pulmonary emboli in these islands has been noticed for many years and reference to the fact has been made repeatedly. However true this observation that was made a long time ago, it is to our great discredit that it has been allowed to go so long without challenge or confirmation.

This study demonstrates conclusively that although not common, fatal pulmonary emboli in Hawaii are by no means rare. The report of 40 fatalities in a period of 6 years verifies the serious potentialities of thrombotic conditions and signifies the need for developing an attitude of constant vigilance for the detection of an intravascular clot and the prevention of a fatal pulmonary embolus.

It is regrettable that a precise therapy discussion cannot be given at this time, as there is a growing suspicion that despite the appreciable progress that has been made in thromboembolism, the effectiveness of measures currently used is definitely limited, as evidenced by the reported failures. It is the consensus that thrombophlebitis is a generalized thrombotic disease and the rationale for vein interruption, at the superficial femoral junction, has been the belief that the majority of emboli originate distal to this point. It would appear from the evidence available at the present time, and I am inclined to agree with it, that vein interruption, in the majority of instances, is not basically sound. As the elderly people comprise an increasingly larger part of our population, the problem of thromboembolism will increase in magnitude.

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# The Treatment of Alcoholism, with Special Reference to Antabuse Therapy

J. ROBERT JACOBSON, M.D.
HONOLULU

THE problem of alcoholism is of interest to all doctors because these cases are so common, they are so difficult to treat, and our treatment facilities and technics are so limited. The environment plays a tremendous role in alcoholism. Drinking is part of the cultural pattern, and its primary objective is release from the tensions, worries, fears, and depressions which arise in the individual because of the pressure of the environment. Alcoholism is at least superficially and directly an environmental disease in the same manner as a contact dermatitis. The obvious cure would be effective prohibition but we must admit that practically there is no such thing.



DR. JACOBSON

When we talk about alcoholics, we refer to that group of drinkers who suffer as a result of drinking; who become intoxicated too often, are unable to work regularly because of drinking, cannot maintain their social relationships intact, and who may behave anti-socially when drunk. Extreme disturbances of personality, such as cases of delirium tremens, Korsakoff psychosis, paranoid trends, or pathological intoxication with its delirioid reactions, are not of particular interest to the general medical man since they are usually handled by the psychiatrist in segregated treatment units or in mental hospitals. For this reason, this discussion will be limited to the treatment of non-psychotic alcoholics.

We must realize that many different kinds of personalities drink and that they become addicted to drinking in different ways and for different reasons. We might talk about the man who is chronically depressed in mood who finds that alcohol lightens his depression. We might discuss the individual who is allergic to depression and escapes into gaiety and lightheartedness without alcohol, but finds that alcohol helps him escape more readily. We might talk about the so-called paranoid individual, the chronic sorehead, who when drinking becomes more convinced of the justice of his complaints, especially when drinking with other irritable, resentful personalities. We might talk about the explosive type of individual who finds alcohol an excuse for anti-social behavior which he could not contemplate when sober. We might discuss the individual who cannot socialize readily when sober, who is inclined to be shy, timid, and self-conscious, but who readily meets other people when bolstered up by liquor. We might include those occult personality disturbances of the manic-depressive type in which alcohol is a subordinate part of the personality disturbances. It is not my purpose here to digress into these aspects of the problem of alcoholism, since such a discussion is not suited to this occasion.

The alcoholic is amenable to treatment only when he has a serious realization of the effects of alcohol on his life. This realization comes to him when an emergency arises. He has been drinking steadily and heavily for a length of time. He is neglecting his business or is threatened with the loss of his job. His family is alarmed and his wife is contemplating divorce. Some particularly disturbing episode may have taken place, such as an assault on some member of the family, a car wreck, or some criminal act. The patient may have had a recent episode of delirium tremens which made him realize the serious effects of alcohol on him. The alcoholics who have come to me for treatment have come as part of some emergency which has temporarily made them amenable to treatment. I am therefore interested to read in an article in the Oct. 27, 1951 issue of the AMA *Journal* that "Patients who come for treatment under duress with the sword of some threat poised over their heads (perhaps the threat of a wife that she will divorce a husband unless he undergoes treatment or that of a father that he will disinherit his son) are not good candidates for therapy." If the poor candidates for therapy—as described in the article cited—were eliminated from my prac-

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tice, I should have no alcoholic patients. I wonder who these desirable patients, these good candidates for therapy, are, and why I have not seem them. My conclusion is that they are taking care of themselves. While I am sure that all of us would prefer this type of patient, I am equally sure that few doctors see them.

Emergencies such as those mentioned do bring about in the individual a willingness, perhaps a pathetic eagerness, to be treated. It is true that these patients usually have only a limited desire to stop drinking. Their realization of the dire effects of alcohol changes as the emergency lifts. Time dims the memory and the urge to drink has a tendency to recur in all its pristine attractiveness. The alcoholic whom the doctor sees is, however, a sick man—shaky, tremulous, unable to eat. He requires sedation, vitamins, parenteral feeding and a short period of hospitalization. The doctor begins by treating the immediate effects of the alcohol, realizing that this is not treatment of the primary illness—the abnormal urge to drink and the pathological sensitization to alcohol.

After the patient has recovered from the effects of alcohol, the problem of treating the alcoholism itself arises. One form of treatment is sub-coma insulin. In a certain number of patients, this treatment brings about an improved nutritional state. They become mentally more alert and they feel better, but the essential urge to drink and the sensitization to alcohol remain unchanged. Electric shock treatment can be given, but certainly with no real expectation of changing the patient's state as an alcoholic. I should like to emphasize, however, that electric shock treatment may be very effective in an alcoholic in whom an affective syndrome is playing a role. I am not talking about psychotic patients, but have in mind a patient who periodically indulged in alcoholic debauches in which he consumed an entire quart of whiskey in less than an hour. There was such a frenzy behind his drinking and behind his intense need for sedatives in the hospital that I became convinced that this anxiety tensional state was analogous to a manic depressive syndrome. Two electric shock treatments completely cleared up his tensional state and he then got along very well for the next few months.

Another form of treatment which has its field of effectiveness is conditioning therapy. It is a positive form of treatment. It is heroic and certainly requires strong motivation on the patient's part. Among the drawbacks of the aversion treatment are the facts that only a small percentage of patients will accept it, and that the percentage of good results is not high. In some patients, however, it does result in a period of abstention from drinking.

Antabuse therapy represents an improvement over the conditioning therapy. The Antabuse-alcohol test situation has some conditioning value and in the hands of some, the test situation is repeated and the conditioning aspects of the treatment are emphasized. I confess I do not care for that emphasis. To me, the important part of the treatment is the giving of the tablets daily by some member of the family, the regular visits to the doctor, and the establishment of a familiar medical routine. This medical routine in turn establishes the alcoholic as a sick man, and as long as he accepts his role in this situation, the therapeutic value continues. It is this aspect of Antabuse therapy which is such a valuable addition to our armamentarium in the treatment of alcoholism.

Antabuse is not free from risks, but these risks are statistically not too great, in the light of the serious nature of the illness and its disorganization of the patient's life situation. Let us consider the dangers of the Antabuse-alcohol test. I must confess that every time I administer this test in the hospital, I am as concerned as the patient himself. When blood pressure drops to 60/0, I think any doctor would become a bit uneasy, particularly when he knows that there is no way of stopping the further effects of acetaldehyde poisoning and that the patient is going to get worse before he gets better.

When I first began using Antabuse in 1949, there was nothing in the literature describing modifications of the test procedures which would lessen the dangers. In fact, the published article available then stated that the patient should be permitted to drink at his own rate and as much as he wished, until he became too sick to continue. I soon decided to lessen the dangers by giving alcohol in measured amounts at regular intervals and by taking blood pressure and pulse every five or ten minutes. I may start with 1 ounce of alcohol and then give one-half ounce every ten minutes. I stop the alcohol at 3 or 4 ounces. If there is no significant physiological response with that amount, I let it go at that, preferring a relative failure in conditioning to possible catastrophic responses. Later literature—articles published in 1951 and the Ayerst, McKenna and Harrison brochures issued since Antabuse was released for general use in October, 1951—state that one ounce of alcohol is all that need be given in the test situation. It is, however, my experience that one ounce produces such slight physiological effects in most patients that there would be no conditioning

value whatever and the test situation might as well be dispensed with.

The possibility of a rare death must be included in the Antabuse-alcohol test situation. Jones, for example, reported a death after the patient had been given only one ounce of rum. I always emphasize this rare possibility to my patients before they sign the permit.

The next problem that confronts us in Antabuse therapy is that of side effects on the daily maintenance dosage. The original literature suggested daily maintenance dosages ranging from 0.25 gm. (half a tablet) to 0.75 gm. and recommended repeated Antabuse-alcohol reaction tests to determine the adequate maintenance dosage for each patient. I considered the latter undesirable and never used it. I soon became convinced that a dosage larger than 0.25 gm. led to more pronounced side effects, and found it was possible to convince the average patient that whatever dosage he was receiving would make him sufficiently ill if he drank. We are dealing with an individual who has only a weak resolution to refrain from drinking, and the development of side effects, far from being undesirable so far as he is concerned, may actually be the one thing for which he is unconsciously or even consciously looking. It is therefore very desirable to eliminate side effects as an excuse to defeat the therapeutic aim.

Headache and dizziness are common side effects which may be sufficiently severe to endanger the therapy and to require an adjustment of the maintenance dosage. Impotence is another complaint, though I have found that a material reduction in the dosage did not eliminate the complaint so that I seriously doubted its physiological background and felt it was being employed as an excuse to avoid further treatment. A side effect not mentioned in any of the published articles, agranulocytosis, occurred in one of my patients. His white count dropped to 2,500 when he was on Antabuse; rose when Antabuse was discontinued, and dropped again when it was reinstituted. It is interesting that when this patient was placed on Antabuse a year later, no such agranulocytic response developed. An important and very disturbing side effect is the delirioid reaction. Before this had been mentioned in the literature, I had one such case, and two others in which I suspected its presence. In the one definite case, the delirium subsided when Antabuse was discontinued, and returned when even one-fourth of a tablet was given. If a delirioid side effect is suspected, the Antabuse should be temporarily discontinued, and reinstituted in very small amounts, even one-eighth of a tablet.

The medical routines of Antabuse therapy are exceedingly important. I do not trust the patient to take his own medication, but insist that some member of the family or some friend or even the landlady, give it. If the patient fails to keep an appointment, he is called up immediately and reminded to come. The patient should come once a week for at least two months. He may then come every other week for several months, and at longer intervals thereafter as long as he can be influenced to come. I emphasize to the patient that I never look upon him as cured, and I become most concerned when he feels most independent and sure of himself.

Antabuse is not a cure for alcoholism, but is rather a form of medical treatment and supervision. We are therefore justified in calling the results good if the patient abstains from alcohol for a reasonable length of time, perhaps 6 to 8 months, and if he immediately returns for further treatment when he relapses. In other words, the result may be considered good when the total disability from alcohol is materially reduced. The result may be considered fair when the patient abstains from alcohol for a reasonable period of time, or when he drinks less than he did before being treated, so that his total adjustment is somewhat improved. The term poor may be applied to any case in which no appreciable change in the extent of drinking or in the degree of disability from alcoholism takes place.

Of the 63 patients reported on at this time, 13 disappeared after receiving the Antabuse-alcohol reaction test in the hospital and probably should not be included at all since they were never actually on antabuse. They are included because they serve to illustrate the difficulty of holding the private patient to the treatment program. One of the 13 is interesting because he stopped drinking for fifteen months after the reaction test and when he relapsed, returned for further therapy.

TABLE 1.—*Results in Relation to Length of Initial Period of Treatment in 52 Cases of Alcoholism.*

| PERIOD OF INITIAL TREATMENT | NO. | RESULTS % GOOD | % FAIR | % POOR |
|---|---|---|---|---|
| Reaction test only | 13 | 7 | .... | 93 |
| 1 mo. | 9 | 22 | 22 | 56 |
| 2 mo. | 9 | 56 | 22 | 22 |
| 3–12 mo. | 21 | 76 | 24 | .... |

Nine patients remained on treatment for one month after leaving the hospital. Two of them were considered good results, 2 fair, and 5 poor. Nine patients remained on treatment for two months after leaving the hospital. Five of these were good results, 2 were fair, and 2 poor. Twenty-

one cases continued on treatment for three months to one year or more. Sixteen were good results, 5 fair, none poor. Eleven cases were excluded from the table because they included factors which made alcoholism a minor part of the picture.

What about psychotherapy with alcoholics? This aspect of treatment is conspicuous in the literature and the need for group and individual psychotherapy is stressed. In institutional work, I carried on group psychotherapy for years and feel that it has a place in treatment, but in private practice, group psychotherapy is out of the question. It is my experience that alcoholics are peculiarly resistant to psychotherapy, except on the most superficial level. One of my patients, and only one, has gradually grown in the course of time so that the most significant aspect of his office contact is the stimulating nature of the psychotherapy that develops. There is a tendency today to classify the alcoholic as a psychoneurotic; but psychoneurotics, as a group, are peculiarly susceptible to psychotherapy and get well under treatment. I am convinced that the older classification of the alcoholic as a psychopathic personality is much more accurate because the psychopathic personality group is also peculiarly resistant to psychotherapy. Let us grant that only psychotherapy can cure an alcoholic—but let us, as doctors, be realistic and admit that the alcoholic who is amenable to psychotherapy is rarely seen in medical practice. As doctors, we may welcome Antabuse therapy, not as a cure for alcoholism, but as a form of medical treatment which can materially reduce the disability due to alcoholism.

## Discussion

Dr. Morton E. Berk: —The discussion of alcoholism is timely. There is very definitely an increasing need to meet this problem in every community, and ours is no exception. No one has the answer. The problem of alcoholism is not necessarily basically psychogenic, any more than it is socio-economic or a manifestation of some peculiar allergy. These are all factors which may be involved and whenever possible should be corrected.

Since Antabuse is being utilized, it must be remembered that there is no direct attack on the etiology of alcoholism, an etiology which we do not understand. It is simply a method of scaring a person into not drinking and loses its efficacy as soon as the patient stops taking the medicine. The dangers of Antabuse have been pointed out by Dr. Jacobson, and I would like to add just one point more in the form of a plea.

Most doctors do not like to take care of chronic alcoholics. I am one of them. At times it does behoove us to look after an alcoholic in our own practice, and I am strongly of the opinion that the family physician can frequently do a good job in caring for this poor unfortunate medical responsibility.

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# *The President's Page*



## THE DOCTOR AND THE LAYMAN

The ancient Greek physician was a slave. In most cases his education was superior to his master's. Time has changed the status of the physician only in degree. Truly he is a servant to his patients. Because of this service and the educational background, physicians have become respected members of the communities in which they live. They have frequently become leaders in non-medical civic projects.

In this age of unsettled attitudes there has been developing distrust of the medical profession by the laymen—the most noticeable as a result of our fight against socialized medicine. A closer relationship between doctor and layman can do much to maintain dignity and confidence in our profession.

We have not been idle. Our medical society has offered service and leadership to organizations interested in public health and sanitation, poliomyelitis, cancer, tuberculosis, heart disease and many other fields in which the lay people have taken an active interest.

At the last meeting of the Plantation Physicians on the Island of Maui, the public was invited to several sessions where medical problems were discussed. The interest and enthusiasm were marked. We can well be proud of the manner in which our medical radio programs are being conducted and received. Any program which creates a more friendly and more informed understanding with the public merits support and encouragement.

Organized labor have been studying their medical program for some time. Their decisions may be of vital importance to every member of the Territorial Association. All are directly or indirectly affected. Service, leadership, friendship, cooperation and understanding may aid labor in arriving at a practical and efficient program. A new committee on Industrial Relations is studying this problem. Their report, at the very least, should keep the Society apprised of changing situations.



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# [EDITORIALS]

## FLUORIDATION OF DRINKING WATER

Most of the questions that have been raised about the fluoridation of drinking water for the prevention of dental caries have now been answered to the satisfaction of nearly all open-minded persons and to the official satisfaction of all of the national organizations whose concern, in whole or in part, this problem is.

Fluoridation *is* effective in reducing the incidence of dental caries. Fluoridation *is* safe. Fluoridation is *not* expensive; indeed, it has saved far more than its cost in every city in which its effect has been studied.

One question is still being debated: is fluoridation an invasion of human rights? Has a human being an inalienable right to drink unfluoridated water if he wants to?

It seems to us that he has exactly the same right to be furnished with unfluoridated water that he has to be furnished with unpasteurized milk, or with water from which typhoid bacilli have not been removed—in other words, a very dubious right, or more properly no real right at all.

The fact is that the average citizen, while he may regard the character of his drinking water as his own business, regards his (or his children's) dental caries as the community's business; he expects them to be cared for by the community's dentists, and if he can't pay for it he expects the bill to be assumed by his neighbors.

By this attitude, we believe, he relinquishes his right to object to any safe, effective, inexpensive method of reducing the incidence of dental caries in his community and in himself and his children, —just as, by expecting the community to bear the burden of the cost in the event of his getting typhoid fever, he relinquishes the right to be furnished with contaminated water.

The true liberal may regard this as a loss of human rights, an invasion of freedom—and so it is. But isn't it "for the greatest good of the greatest number"? We think so.

## ST. FRANCIS HOSPITAL RESIDENCY APPROVED

Sister M. Jolenta, Administrator, announces that St. Francis Hospital has been notified of the approval of its Obstetrical-Gynecological Residency Program by the American Medical Association's Council on Medical Education and Hospitals.

This official recognition results from a survey of the hospital facilities and educational program by Dr. Edward Leveroos, Secretary of the Council, from Chicago, Illinois. The program is approved for advanced training of Residents in this specialty. The Attending Staff in this Department consists of: Dr. K. S. Tom, Chief; Drs. S. Nishijima, J. Wong, L. Thouin, and Lucy Ma.

The Resident assigned to this department of the hospital is Dr. Lucida Cuajunco, graduate of the University of the Philippines Medical School.

## "NEEDLESS" REFERRALS

What do you say to parents, Doctor, when you find nothing wrong with their child's eyes, despite the fact that the school nurse or teacher thought there was a visual defect?

Do you tell them there's nothing wrong and let it go at that? Leaving them with the feeling that (1) the teacher or nurse was foolish to raise

the question in the first place, and (2) you yourself were pretty greedy to expect a fee when there was nothing wrong with the child?

Or do you explain to them tactfully that they are lucky their child is in a school where the nurses and teachers are concerned about more than mere studies, and alert to the possibility of physical defects or illnesses, and doubly lucky because whatever raised the question in the first place is no longer present and their child has normal eyesight?

Richard G. Scobee of St. Louis, writing in a recent issue of the *American Journal of Ophthalmology*, urges—for obvious reasons—the latter course. It results almost always, he says, in gratitude on the parents' part, to the physician for reassuring them and to the school for taking a constructive interest in their child's physical well-being.

Sometimes the need for tact is as great in the delivery of good news as it is in the delivery of bad news. Of such stuff is the Art of medicine made.

## THE NEW ARTIFICIAL RESPIRATION

The back-pressure arm-lift, back-pressure hip-lift, and chest-pressure arm-lift methods of artificial respiration have replaced the Schaefer Prone Pressure method for use in the United States Army. These new methods are described in detail in Training Circular No. 15, issued March 25, 1952.

In essence, the back-pressure arm-lift consists of alternating pressure over the ribs from behind, with upward and forward pull on the victim's flexed elbows—the operator kneeling at the victim's head and facing him. In the back-pressure hip-lift, the hips are lifted from the ground in lieu of the raising of the victim's elbows—the operator's position being similar to that in the Schaefer method. The third method is done with the victim supine instead of prone, and alternates pressure over the costal cartilages (with the victim's wrists in the operator's hands) with full caudal extension of both the victim's arms.

Some tests done with these methods suggest strongly that they are more effective in securing respiratory exchange, than the old Schaefer method so long taught in first aid classes. Certainly they should be learned by all persons entrusted with the administration of first aid, particularly first aid to the drowned or electrically shocked.

Training Circular No. 15 is a careful, detailed, explicit, well-illustrated presentation of all three methods, and interested persons would do well to secure a copy of it for their instruction.

## NONSURGICAL TREATMENT OF CATARACT

Resolution of cataracts, accompanied by progressive improvement in vision, has been reported by Shropshire, Ginsberg and Jacobi, from the Cataract Institute in South Kortright, New York, in a series of 26 patients treated with injections of fish lens extract.[1]

The exact method of preparing the extract is not given, but the article states that comminuted lenses are extracted with a physiologically compatible solvent, insoluble residues are removed, and the solution is sterilized. A dose of 1 cc. is then administered by injection, presumably subcutaneous, three times a week. Twelve cases are reported in detail, together with the improvement of vision in each eye, and a before-and-after pair of ophthalmoscopic photographs is shown as well.

An additional 100 cases are to be the subject of an extensive and more detailed report; the present communication is a preliminary one and rather brief.

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[1] Shropshire, R. F., Ginsberg, J. R., and Jacobi, M.: The Nonsurgical Treatment of Cataract, Science 116:276 (Sept. 12) 1952.

# THIS IS WHAT'S NEW!

Remedy #57: **Ascorbic acid** 25 mg. and **menadione bisulfite** 5 mg. by mouth daily for 30 days controlled the **nausea and vomiting of pregnancy** in all 70 patients so treated by Merkel (*Am. J. Obst. & Gyn.* 64:416 [Aug.] 1952).

(Notice: Henceforth new "remedies" for hyperemesis gravidarum will be ignored by this column. Women have been, and undoubtedly will continue to be, women.)

Reviewing the problem of **antibiotic combinations,** Jawetz offers a simple scheme for clinical use. He classifies the antibiotics in two groups:

I. Penicillin, streptomycin, bacitracin, neomycin
II. Aureomycin, terramycin, chloramphenicol

Members of group I are frequently synergistic with each other, never antagonistic. Members of group II are simply additive with each other. A member of group II will probably be antagonistic to a group I drug if used on an organism susceptible to the group I drug. Conversely, a group II drug will probably be *synergistic* with a group I drug when used on an organism *resistant* to the group I drug. (*Arch. Int. Med.* 90:307 [Sept.] 1952.)

Enthusiasm Undimmed: Despite the consistent failure of the drug to accomplish anything in anyone else's hands, Evan and Wilfrid Shute continue to glow about alpha tocopherol **(vitamin E).** Latest: Acute and chronic **thrombophlebitis** yield to the "fibrinolytic" action of E. The reason results in the U.S. are so poor: our market is "flooded with preparations . . . of dubious potency." (*Am. J. Surg.* 84:187 [Aug.] 1952.) We're still dubious.

Ordinary penicillin has two disadvantages in treating meningitis: poor diffusion from the blood into the cerebrospinal fluid, and local irritation with intrathecal use. These flaws are remedied with **Neopenil** (Smith, Kline & French), hydriodide of diethylaminoethylester penicillin G, which appears in the **spinal fluid** in concentrations 10 times greater than those produced by equal IM doses of other forms of pencillin (Schimmel, et al., *Am. J. Med. Sci.* 224:247 [Sept.] 1952).

Joining the chorus: of praise for **amphetamine** in the treatment of **barbiturate poisoning** is H. L. H. Dick who says it's the agent of choice after his happy experiences in treating 11 patients. All recovered, though 2 were in shock and apneic. (*Am. J. Med. Sci.* 224:281 [Sept.] 1952.)

Mention only to condemn: **intravenous procaine** (250 cc. of 0.1 to 0.2% solution) produced no measurable change in digital cutaneous blood flow in 9 patients with **occlusive arterial disease,** under controlled conditions. (*Am. J. Med. Sci.* 224:300 [Sept.] 1952.)

**Triethylene melamine** (TEM), used heretofore in the treatment of neoplastic disease, is reported to have produced satisfactory remissions in 20 of 30 patients with **polycythemia vera** treated by Rosenthal and Rosenthal (*Arch. Int. Med.* 90:379 [Sept.] 1952). Remissions beginning in 4 months and lasting about 9 months were obtained with 15 to 65 mg. by mouth.

When intrapleural streptomycin is used in treating **tuberculous empyema,** continuous alkalinization of the empyema fluid is necessary to prevent inhibition of streptomycin by pus, which has an acid reaction. Ståhle accomplishes this by instilling **cellugel** (1 per cent solution of sodium carboxymethyl cellulose) along with the streptomycin. (*Am. Rev. Tuberc.* 66:285 [Sept.] 1952.)

Temporary (30-60 minutes) relief of spasticity in patients with **multiple sclerosis** after ingestion of **mephenesin elixir** (Elixir Tolserol) is reported by Libet and Rubin. (*J. Nervous & Ment. Dis.* 116:198 [Sept.] 1952). Large doses (1-2 gm.) were necessary, and chief usefulness of the drug is in facilitating physical therapy sessions.

C. A. Domzalski, Jr., M.D.

# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*
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Closed Saturdays at noon and Sundays
Closed all day and evening on National holidays
and at noon on Territorial holidays

## Recent Acquisitions

**Biochemistry**

Luck, J. M., ed. *Annual review of biochemistry.* v.21. 1952.

**Biography**

Olmsted, J. M. D. *Claude Bernard and the experimental method in medicine.* c1952. (gift of publisher).

**Cancer**

Nettleship, Anderson. *Basic principles of cancer practice.* c1952.

**Cardiology**

Boar, E. P. *The heart rate.* c1932. (gift of Dr. Hunter).

**Dietetics**

Hildreth, D. M. *The low fat diet cook book.* c1952. (gift of publisher).

**Endocrinology**

Ralli, E. P., ed. *Adrenal cortex. Transactions . . . 3rd conf., Nov. 15/16. 1951.* c1952. (gift of Josiah Macy, Jr. Foundation).

Shock, N. W., ed. *Problems of aging. Transactions . . . 14th conf., Sept. 7/8, 1951.* c1952. (gift of Josiah Macy, Jr. Foundation).

**Genito-Urinary System**

Bradley, S. E., ed. *Renal function. Transactions . . . 3rd conf., Oct. 18/19, 1951.* c1952. (gift of Josiah Macy, Jr. Foundation).

Dodson, A. I. *Synopsis of genito-urinary diseases.* 5th ed. c1952. (gift of publisher).

**Hematology**

Mudd, Stuart, ed. *Blood substitutes and blood transfusion.* c1942. (gift of Dr. Hunter).

Quick, S. J. *The hemorrhagic diseases.* c1942. (gift of Dr. Hunter).

**Infectious Diseases**

Culbertson, J. T. *Living agents of disease.* c1952. (gift of publisher).

**Medicine**

*Physician's handbook.* 7th ed. c1952. (gift of publisher).

Youmans, J. B., ed. *Medicine of the year, 1952.* (gift of Hawaii Territorial Medical Association).

**Nursing**

Dock, L. L. *A short history of nursing.* 4th ed. c1938. (from Nurses' Association).

**Ophthalmology**

Duke-Elder, Sir Stewart. *Textbook of ophthalmology.* v.5. 1952.

Pascal, J. I. *Studies in visual optics.* c1952. (gift of publisher).

**Orthopedics**

Hart, V. L. *Congenital dysplasia of the hip joint and sequelae.* c1952. (gift of publisher).

Lichtenstein, Louis. *Bone tumors.* c1952. (gift of publisher).

**Pathology**

Anderson, W. A. D. *Synopsis of pathology.* 3rd ed. c1952. (gift of publisher).

**Physical Therapy**

Buchwald, Edith. *Physical rehabilitation for daily living.* c1952. (from Hawaii Chapter, American Physical Therapy Association).

**Surgery**

Bancroft, F. W., ed. *Operative surgery.* c1941. (gift of Dr. Hunter).

**Miscellaneous**

American Medical Association. *Standard nomenclature of diseases and operations.* 4th ed. c1952.

American Hospital Association. *Job descriptions and organizational analysis for hospitals and related health services.* 1952. (from Nurses' Association).

Beebe, G. W. *Battle casualties.* c1952. (gift of publisher).

Gibson, H. L. *The photography of patients.* c1952. (gift of publisher).

Kemp, L. A. W. *A student's radiological mathematics.* 1951. (gift of publisher).

Lederle Laboratories. *Aureomycin bibliography and index.* 1951 ed. c1952. (gift of publisher).

* * *

The Library wishes to acknowledge with special thanks the generous offer of Dr. Cloward to assume the cost of binding several journals in the field of neurosurgery. Dr. Cloward has given us his back files of the *Journal of Nervous and Mental Disease, Journal of Neurophysiology, Brain* and the *Bulletin of the Los Angeles Neurological Society,* and is also contributing current issues. The gift of these journals represents a definite saving in our subscription budget. Moreover, binding costs are a considerable item each year, and in financing this project, Dr. Cloward is making an outstanding contribution.

Several new journals have recently made their appearance in the Library. One is *Laboratory Investigation,* the official organ of the International Association of Medical Museums. Dr. Hosoi has been kind enough to promise us his copies of this journal, and he also brings in regularly the *Journal of Heredity* and *Scientific Monthly. Diabetes,* a new journal devoted to this subject, is donated by Dr. Berk, and we are also indebted to him for the *British Heart Journal.*

Last month we were pleased to receive the annual contribution of $37.50 from the local chapter of the American College of Physicians. This is to cover the cost of the *Internal Medicine* section of *Excerpta Medica.*

For these and all other books and journals given us by many of our members, we wish to express our sincere appreciation.

# BOOK REVIEWS

## Physician's Handbook.

By Marcus A. Krupp, M.D., Norman J. Sweet, M.D., Ernest Jawetz, Ph.D., M.D. and Charles D. Armstrong, M.D., Seventh Edition, 380 pp., Price $2.50, Lange Medical Publications, 1952.

The seventh edition of the Physician's Handbook is once more the handiest little book of its kind for all physicians. The tables include anything from milliequivalent conversion tables to food nomograms. The other sections have been improved and advancements have been incorporated.

Of particular interest is a short section on radioactive isotopes. To those of us in the Territory, who have no access to them, it should be interesting because of the compact review that is presented.

The section on mycology is also well done and there is considerable improvement in many other sections such as fluid and electrolyte balance and electrocardiography.

There is so much information concentrated in this pocket size book of 380 pages, and the cost of it is so little, that it is almost a "must" for every physician, whether general practitioner or neurosurgeon, gynecologist or internist. Even the roentgenologist will find much of value in this compilation of factual medical material.

MORTON E. BERK, M.D.

## Brain Tumors of Childhood.

By Henry M. Cuneo, M.D., and Carl W. Rand, M.D., 222 pp. with 73 illustrations, Price $5.75, Charles C. Thomas, 1952.

This monograph presents the authors' experiences with 83 cases of brain tumor in children. Succinctly written with clear pertinent illustrations and very few typographical errors, it proved easy to read. The neurosurgical procedures carried out on these patients were standard, and it is interesting that treatment and results have changed very little since Bailey, Buchanan and Bucy published their work thirteen years ago. The reviewer was glad to see that the authors condemn ventricular estimation as a misleading diagnostic test.

This book is highly recommended to pediatricians and others wishing to gain rapid insight into these important problems.

LT. F. E. BENNETT, M.C.

## Battle Casualties.

By Gilbert W. Beebe, Ph.D., and Michael E. DeBakey, M.D., 277 pp., Price $10.50, Charles C. Thomas, 1952.

"Battle Casualties" is the first text I have seen which points the way to a logical approach to medical planning. Based on data contained in official records of the Army Medical Service and edited by authors with military experience and enviable reputations in the professional and research fields, anyone concerned with planning for large numbers of casualties in disaster or war will find this volume most helpful and may use it with complete confidence.

COL. T. J. HARTFORD, M.C.

## The Photography of Patients.

By H. Lou Gibson, F.B.P.A., A.P.S.A., 117 pp. with 93 illustrations, Price $5.50, Charles C. Thomas, 1952.

This is a short manual discussing in simple language the principles which must be followed to obtain good clinical photographs. It is printed on good quality paper and is well illustrated. The subject matter includes a discussion on lens properties, positioning and lighting, films and filters and printing methods. A professional photographer would find this material elementary, but a physician or institution interested in phtotographing patients should find this book useful.

I. L. TILDEN, M.D.

## Synopsis of Pathology.

By W. A. D. Anderson, M.A., M.D., F.A.C.P., Third Edition, 788 pp., illustrated, Price $8.00, C. V. Mosby Company, 1952.

This pocket size, 788 page book is an abbreviated but nevertheless complete version of Anderson's large textbook. The Synopsis is the unified work of thirty-two experienced pathologists considered to be experts in various phases of anatomic pathology. The present edition is up-to-date with incorporations of the latest advances in pathology and recent references to medical literature. The text is copiously illustrated, brief, and easily readable. In the reviewer's opinion, the Synopsis is an excellent book for quick reference work, general survey reading or as a guide to past and current articles in medical periodicals.

RAID CHAPPELL, M.D.

## Physical Diagnosis.

By Harry Walker, M.D., 461 pp., with 126 illustrations, Price $8.00, C. V. Mosby Company, 1952.

This book on Physical Diagnosis is compact, nicely organized and well presented. The author has included all of the valuable physical signs and wisely omitted some of the obsolete ones.

An excellent review for all practicing physicians!

ALBERT H. ISHII, M.D.

## Surgery of the Peripheral Nerves.

By Emil Seletz, M.D., F.A.C.S., F.I.C.S., 212 pp. with 136 illustrations, Price $10.75, Charles C. Thomas, 1951.

This 8½ x 11 inch atlas illustrates the surgical technic involved in suturing peripheral nerves, and is based on the author's experience with 2037 peripheral nerve injuries. The surgical anatomy is well illustrated, but the photographs of patients suffer from inadequate contrast.

The tables of information, tests for nerve and muscle function, and original new drawings, particularly of the brachial plexus, make this a highly recommended book for all those concerned with operative repair of peripheral nerves.

LT. F. E. BENNETT, M.C.

### The Low Fat Diet Cook Book.

By Dorothy Myers Hildreth, Dietitian, and Eugene A. Hildreth, M.D., 160 pp., Price $2.95, Medical Research Press, 1952.

Most patients find it difficult to translate lists of foods allowed or disallowed into three meals a day. It is sometimes even more difficult for the cook in the household. This cook book should prove very helpful to many patients as an aid in following a physician's prescription for a low fat diet.

In Hawaii, however, we have many individuals whose food patterns differ radically from the "typical American" pattern followed in the book. To them such a cook book without considerable direction may be a real hazard, changing the food habits in two directions at a time when they are already somewhat confused. The desserts particularly are foreign to Hawaii's food habits and they fill one third of the section of recipes. Perhaps more emphasis should have been given to the necessity of trimming all fat from meats before cooking.

In spite of repeated warnings in the *Journal of the American Medical Association,* mineral oil salad dressing keeps recurring in therapeutic diets. It is not very appetizing and the loss of fat soluble vitamins may be serious if it is used regularly. Vinegar or lemon juice can be used with the usual seasonings for French dressing but no oil, and is quite satisfactory.

However, aside from these rather minor points, the book is a distinct contribution to the practical application of diets which include less than 35 grams of fat. The question of cholesterol is discussed in two short paragraphs which seem to ignore evidence that the body can produce cholesterol from any type of fat and fat from any nutrient containing carbon, hydrogen and oxygen. If this diet is continued for any long period, there is a question as to the adequacy of the essential fatty acids supplied by these low amounts of fat.

MARJORIE G. ABEL, M.S.

### Disorders in Perception.

By Morris B. Bender, M.D., 109 pp., Price $3.00, Charles C. Thomas, 1952.

Dr. Bender's monograph on "Disorders in Perception" is an excellent résumé of his investigation over a period of several years. His findings are exceedingly valuable in localizing lesions in the brain and spinal cord, and serve to differentiate in some cases between the organic and functional types. He makes use of the double simultaneous stimulation method, which was first employed by Oppenheim in 1885 and later by many eminent neurologists. Where single stimulation often fails to reveal the particular locality in the brain, double simultaneous stimulation will invariably clear the problem. The normal sensory pattern in a double stimulation test, the abnormal exaggerated extinction or displacement of the stimulus in disease, and the summary of the theories of extinction phenomena are all interestingly explained and clearly analyzed.

The monograph is short and concise; it can be easily read and understood because of the many illustrative cases, which cover all forms of cutaneous, visual, auditory, and taste sensations, even mental changes, which are carefully recorded. The phenomena of extinction or displacement, being part of the test, make the method useful in clinical and research studies. However it is a splendid example of painstaking research in a special field with good and interesting results for all. I feel that with a little practice, the test can be executed as quickly as any patella reflex test.

As an aid to better neurological diagnosis, I would recommend the lecture to every doctor of medicine, who I am certain will find it well worth reading.

MON-FAH CHUNG, M.D.

### Bone Tumor.

By Louis Lichtenstein, M.D., 315 pp. with 155 illustrations, Price $10.50, C. V. Mosby Company, 1952.

For many years Dr. Lichtenstein, in conjunction with Dr. Henry L. Jaffe, has published numerous papers on bone tumors. Most of their investigations and conclusions were based on the material obtained at the Hospital for Joint Diseases in New York City. This book is an attempt on the part of the author to consolidate and bring up to date all his previous published papers on the subject. Also for completeness he has added new sections which increase the utility and coverage of the book.

It is well recognized that as much mischief can be done by overdiagnosis as by failure to recognize malignant tumors promptly. There is considerable emphasis placed on very accurate diagnosis as a basis for appropriate therapy. This is accomplished by familiarity with the distinctive features of each of the different bone tumors. Experience has taught the author that all roentgen impressions of skeletal lesions should be verified by tissue examinations before one proceeds with definite treatment, whatever the tumor may be. I certainly agree.

For a book on bone pathology, this book is very well done. It is well bound and filled with excellent x-ray and microscopic reproductions. It should have its greatest appeal to the orthopedist, pathologist and radiologist.

B. ALLEN RICHARDSON, M.D.

### Selected Studies in Visual Optics.

By Joseph I. Pascal, M.D., 800 pp., illustrated, Price $12.50, C. V. Mosby Company, 1952.

This is an extensive treatise on physiological optics. The style of presentation is excellent and avoids extreme formality such as is so commonly observed in writings of this nature. Optics is an extremely dry subject. Doctor Pascal endeavors to inject interest, color and, at times, humor into some phases of his report. Actually, the book is so complete that it could be used for research work in optics. The formulae are so extensive that one could solve almost any problem in optics by referral to this book. It could be used by ophthalmologists, opticians and optometrists. There is very little in it which correlates various somatic and functional complaints with errors of refraction. One gets the impression, however, that the author would like to go into such correlations if it were not for the extensive material required in a complete book on visual optics.

OGDEN D. PINKERTON, M.D.

### The Other Side of the Bottle.

By Dwight Anderson, 250 pp., Price $3.00, A. A. Wyn, Inc., 1950.

The Other Side of the Bottle was written by Dwight Anderson, a recovered alcoholic. In his gratitude for returned health and peace of mind he wrote this book as an encouragement to alcoholics and with the desire to develop an understanding of the alcoholic. He presents a readable account of alcoholism in all its aspects and describes the treatments available now and in the past.

JOHN G. LYNN IV, M.D.

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Hawaii County Medical Society was held at the Lanai at 6:30 p.m. August 28, 1952, with Dr. S. Kasamoto, presiding. There were 15 members present. Guests included: Drs. L. G. Thouin of the Medical Group (Honolulu), G. Lambert and G. Stemmermann of the Hilo Memorial Hospital, and Mr. E. O. Williams of the Hilo Chamber of Commerce.

The next meeting will be a semi-annual affair. The Woman's Auxiliary to the Hawaii County Medical Society suggested a joint dinner party next month. Programs will be made by the Auxiliary.

The status of Dr. C. L. Phillips, who is at present confined due to illness, was discussed. It was moved and seconded by Dr. C. Crawford and Dr. Woo, respectively, that we retain him on the active list and that we waive his county medical dues until he recovers. Passed unanimously.

Mr. E. O. Williams of the Hawaii Chamber of Commerce, as a representative of the chambers of commerce, appealed to the medical members for membership.

There being no further business, the rest of the evening was turned over to the speaker of the evening, Dr. L. G. Thouin of Honolulu, who spoke on the "Principles of Treatment in Gynecological Endocrinology," with slides. An extensive discussion followed with everyone participating.

The meeting adjourned at 9:45 p.m.

RICHARD A. YAMANOHA, M.D.
*Secretary*

## HONOLULU COUNTY MEDICAL SOCIETY

On behalf of the Society the Board of Governors welcomed Drs. Scott C. Brainard, Fugate Carty, Angie Connor, Kenneth K. F. Ing, John Sedgwick, Jr., Cecil A. Saunders, Jr., Andrew L. Morgan, Herbert G. Pang and Dorian Paskowitz.

New associates are: Lt. Thomas E. Mattingly, Jr., Lt. Jack C. Todt, Lt. William H. Sage, Major Ervin A. Kjenaas, Cdr. Carl M. McCandless and Lt. Col. Robert C. Hunter.

On September 5 the Honolulu County Medical Society held their regular monthly meeting at 7:30 p.m. in the Mabel Smyth Auditorium. Dr. Wiilliam S. Ito presided with approximately 75 members and guests present.

A recording of the Alameda County Medical Society's excellent public relations program was presented.

Dr. John G. Lynn presented a case study of the neuropsychiatric aspects of a multiple personality. Slides were shown and Dr. John J. Lowrey commented on the case.

Mr. William Meyer discussed the Durham-Humphrey Act and its effect on prescription writing.

Dr. M. Hasegawa spoke of a pediatrician's sojourn in Boston, "The Hub of the Universe."

At the close of the meeting, 10:00 p.m., refreshments were served on the Lanai.

The October monthly meeting was held October 3 at 7:30 p.m. in the Mabel Smyth Auditorium. Dr. William S. Ito presided, with approximately 90 members and guests present.

A panel discussion with members of community service organizations was held in order to inform the Society of their activities in relation to the physician. Representatives from the Sultan Foundation, Child and Family Service, Catholic Social Service, Red Cross, Department of Public Welfare, City and County Health Department and the Oahu Health Council outlined the activities of their respective organizations.

Mr. J. R. Veltmann discussed the current Territorial medical-labor problem in an address entitled, "He Who Controls the Payment of Medical Care Costs, Controls Medicine." A vigorous pro and con discussion followed.

HMSA's request for an increase in the Income Clause from the present $3000-$4000 bracket to $3600-$4800 was approved. It was felt that this increase was warranted as the present income clause is no longer equitable and has been encountering sales resistance in many instances.

The Society unanimously approved the local Diabetes Detection Drive under the chairmanship of Dr. Morton E. Berk. Doctors were again requested to test urine for sugar only, with no charge to their patients, during the National Drive, November 17-23.

There being no further business the meeting adjourned at 10:45 p.m. to refreshments on the Lanai.

C. M. BURGESS, M.D.
*Secretary*

## KAUAI COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kauai County Medical Society was held on Tuesday, August 12, 1952, at the G. N. Wilcox Memorial Hospital Library. The meeting was called to order by the President, Dr. Brennecke, at 7:30 p.m. Other members present were Drs. Wallis, Ishii, Fujii, Cockett, Masunaga, Kemp, and Kim.

A public service memorandum from the AMA on the matter of the RKO-Radio short subject film entitled "Your Doctor" was discussed. According to the circular, the film is supposed to show how medical students are trained, how a doctor in a rural mountain community takes care of his patients, and how all physicians keep in touch with medical progress. The Secretary was appointed to investigate the matter of having the film shown in local theaters.

The following correspondence was discussed:

1. Postgraduate Committee: Dr. John Bell, Chairman of the Postgraduate Committee, informed the Society that plans for a postgraduate educational program on the outside islands were in progress. In order to start the program around September, he requested information on what the local society desired regarding (1) the type of clinics, seminars or lectures, (2) the subject matter to be covered at each session, and (3) the time and day of the meeting.

*Actions Taken:*

A. Postgraduate Sessions: Voted unanimously to support the program and to inform the Committee of our desire to have postgraduate education on Kauai.

B. Expenses: Voted unanimously that this Society offer to pay the transportation costs from Honolulu to Kauai and for room and board if necessary and to entertain any visiting lecturer coming for the express purpose of giving a postgraduate course.

C. Special Assessment: Voted unanimously to assess each member Ten Dollars ($10.00) a year (the year to end April 1 of each year) for the purpose of defraying expenses of the visiting lecturers. If the funds were found to be insufficient, it was suggested that the deficit be made up from the General Fund.

D. Time and Date: Voted unanimously to hold each session at the regular meeting unless circumstances justified a special meeting.

E. Subject Matter: It was suggested that each session be generally confined to one subject and to have both medical and surgical specialists' views on the matter whenever possible.

2. Hawaii Heart Association: Margaret Sheehan, Executive Secretary, requested information regarding the continuation of the Cardiac Clinic program on Kauai.

*Action Taken:*

It was voted unanimously to cancel the Cardiac Clinic for this summer.

3. Territorial Department of Health: Dr. Richard Lee, Assistant Health Executive, wrote on the matter of radium reconversion. Due to insufficient funds the Health Department, on the recommendation of the Territorial Medical Association, is keeping most of the radium in the Territory in Honolulu. Apparently some misunderstanding has arisen in storing some supply of radium on the outside islands.

*Action Taken:*

It was voted unanimously that this Society help in expediting this reconversion by keeping the Kauai radium supply in Honolulu in view of the fact that present day facilities would enable any physician to obtain a supply within 24 hours' notice.

Dr. Kemp of the local Health Service informed the group that a study on fetal waste was desirable and ideal for Kauai. She asked if each physician could send her a monthly list of pregnant patients. There would be no other data required from the doctors. She pointed out the value of such a study.

Dr. Kim asked the members about the follow-up procedure in suspicious cases found in food handlers' surveys. It was suggested that each private doctor be notified of his case for disposition.

Dr. Wallis brought up the subject of handling accident cases to avoid future misunderstanding. The members generally agreed that some policy be set on notifying and admitting a case to either Wilcox or Waimea Hospital. The President was given authority to contact the Police Department and straighten the matter out. In general, it was agreed that the patient should be asked about his place of work and his physician. If the patient was unable to give such information, then the police were to use their discretion in calling either hospital for emergency treatment.

* * *

The regular meeting of the Kauai County Medical Society was held Tuesday, September 9, 1952, at the G. N. Wilcox Memorial Hospital Library. The meeting was called to order by the President, Dr. Marvin Brennecke. Other members present were Drs. Wallis, Goodhue, Ishii, Wade, Masunaga, Cockett, Kemp, and Kim.

Dr. Wallis was authorized to see the Police Department and make arrangements regarding the management of accident cases.

A letter from Dr. Bell, Chairman of the Postgraduate Committee, asked what subject matter the local members would like to have discussed. The Secretary was directed to answer to the effect that this Society would welcome anyone (from Honolulu or mainland) who could contribute information in any specialized field.

The Keogh-Reed Bill was briefly discussed.

Dr. Kemp, local Health Officer, presented a film on Labor and Childbirth. She asked if there were any objections in showing it in various Health Clinics. No protests were noted.

Dr. Wallis briefly discussed the Weinerman Report regarding the plantation Health Plan.

PETER KIM, M.D.
*Secretary*

## MAUI COUNTY MEDICAL SOCIETY

A dinner meeting was held at the Wailuku Hotel, September 9, 1952, with Dr. Ralph Cloward as our guest. Members present were: Drs. Kanda, Shimokawa, Cole, Burden, Sanders, Underwood, Tompkins, Izumi, Fleming, Kashiwa, Ferkany, H. Kushi, Haywood, Patterson, McArthur, St. Sure and Ohata. Dr. Champagne of Louisiana also attended as a guest.

Dr. Patterson, chairman of the Program Committee, announced that he was arranging a Gynecological Symposium for early in October. It was decided that it would be best to have this as a Sunday morning breakfast meeting. It is expected that two or three men will come from Honolulu as guest speakers to conduct this symposium.

Dr. Cloward presented an illustrated talk on "The Diagnosis and Treatment of Low Back Pain."

Because of the lateness of the hour no other business was taken up and the meeting adjourned at 10:45 p.m.

* * *

A special breakfast meeting was held at Puunene Club at 8:30 a.m., October 5, 1952. Guest speakers were Dr. Lyle Bachman, who spoke on Gynecological Endocrinology, and Dr. K. S. Tom, who spoke on Gynecological Infections.

Following very excellent talks by the two speakers, the meeting was opened for a period of informal questions and answers to the benefit of all present. The meeting adjourned at 11:30 a.m.

EDMUND TOMPKINS, M.D.
*Secretary*

# HMSA—Its Place in the Community

## Journey with an HMSA Claim

J. R. VELTMANN, *General Manager*

An HMSA membership card is recognized in the Territory of Hawaii as a passport to any doctor's office or hospital when seeking medical services. The presentation of a membership card is the beginning of an HMSA claim. Each day approximately 250 claims are received from the 366 participating physicians and 39 hospitals in the Territory. Upon receipt, each claim is date stamped and numbered for positive identification. From a master file, membership status is verified and the claim is processed through the Records Department where individual case history jackets are maintained for every member. The new claim is attached to this case history jacket and processed to the Medical Department.

In the Medical Department, each claim is thoroughly screened and reviewed by a staff of medical pricers operating under the direct supervision of the Medical Director. Each claim is priced in accordance with services rendered per terms of the membership certificate, and each service is coded in accordance with the United States Public Health Service Manual for morbidity and statistical studies. This phase of the operation is essential as anticipated benefit increases, benefit adjustments, and even rate increases are based on the morbidity studies developed from these claims. Medical pricers are carefully trained to detect errors in billing, heavy benefit utilization and possible abuse of the Plan. The more complicated cases are personally reviewed by the Medical Director who is available for personal consultation with doctors or members relative to such claims.

During this screening process, all claims that are incomplete or contain insufficient information, are referred to the Supervisor for further review and in many instances are returned to the doctor for clarification. It is vitally important for doctors to provide complete and thorough reports on each case to avoid unnecessary delay in the proper handling and payment of claims. Ineligible claims receive special attention to avoid misunderstanding or misinterpretation of the certificate benefits.

Properly priced and coded claims are internally audited and further checked through the use of verification notices placed on the member's copy of the claim; these functions are essential for the purpose of protecting the Plan and offering better service to members, participating physicians and hospitals. A majority of claims are processed within four days after they are received at HMSA, but as an economic measure, payments are made only once a month covering all claims received between the 15th of the month and the 10th of the following month. Preparation of claim checks and vouchers is handled through IBM machines and verified for accuracy before being returned to the doctor or hospital with a copy of the claim.

HMSA provides participating physicians with a simple claim form which is completed only once and filed with the Association as soon as the last service is performed for an illness. Hospitals call the Association for service authorization on admission of a member, thereby avoiding necessary financial arrangements by members with hospitals. HMSA is billed on the hospital's own form which is forwarded with a signed report by the participating physician. In the near future HMSA will provide hospitals with a form to simplify billings and furnish necessary data which is essential to maintain accurate statistical records. An HMSA member is not required to complete any portion of a claim form. The member is only required to present his membership card to his doctor or to the hospital.

HMSA processes approximately 5,500 claims for approximately $115,000 each month for Medical-Surgical-Hospital services.

# NOTES AND NEWS

**Dr. Serge Rass** and **Dr. Marge (Kit) Glover** were recently appointed assistant physicians at Kahuku Hospital. Dr. Kit Glover is a graduate of the University of Washington. She served her internship at Queen's Hospital and was resident physician at Kauikeolani Children's Hospital. Dr. Ross' past accomplishments read like a medical travelogue. He is a graduate of the University of Kharkov, Ukraine. Following a year's internship at the General Hospital in Kharkov, Dr. Ross was affiliated with the Tropical Institute in Moscow and spent the next four years in Russian Turkestan on malarial projects. Upon completion of this work he was appointed staff member of the University of Nizhni Novgorod and was soon sent to Western China to study tropical diseases. Instead of returning to Russia he went on to North India where for nine years he was affiliated with an American mission hospital and did research with the Haffkine Institute in Bombay.

In 1941 he left India for Australia where for four years he served the Department of Public Health of New South Wales in the capacity of a bacteriologist. For the next two years he served in the Central Pacific studying poisonous fishes in Fanning Island. Following this he became medical officer in charge at the International Airport in Nandi, Fiji Islands.

Prior to coming to Honolulu, Dr. Ross spent 12 months at Canton and six months at Wake Island as resident physician for the C.A.A.

**Dr. G. Yamashita** returned to Honolulu after three years study devoted to pediatrics. While away Dr. Yamashita divided his time between the Pediatric Department of Harvard University and the Children's Hospitals in Boston and Los Angeles.

Miss Gloria Jo Ann Roberts of Denver, Colorado, is a new clinical psychologist in the office of **Dr. Richard D. Kepner.** Miss Roberts received her Master of Arts degree in clinical psychology from the University of Denver, and served her internship at Colorado General and Psychopathic Hospitals in Denver.

**Dr. Darian Paskowitz** announces the opening of his offices in Aina Haina for general practice. Dr. Paskowitz is a graduate of Stanford University School of Medicine and served his internship in the U. S. Navy Hospital at Shoemaker, California. He was on active duty in the U. S. Navy from 1945 to 1948. He is presently physician for the University of Hawaii, Medical Adviser for Local Draft Board No. 2, President of the Mental Hygiene Society, and President of the Hawaiian Public Health Association, and has been Acting Chief of the Bureau of Venereal Diseases and Cancer Control. He was recently married to Miss Marilyn Schneider of San Francisco.

The Army has recently called **Dr. Francis K. L. Won** of Kailua to active service, and **Dr. Francis F. C. Wong** of Hilo has received a call from the Navy.

**Dr. and Mrs. Harry L. Arnold, Sr.,** and **Dr. and Mrs. Harry L. Arnold, Jr.,** returned in October from a three months' trip to Europe, during which the doctors attended the Tenth International Congress of Dermatology in London, where the junior Dr. Arnold presented a paper on the use of the gooseflesh response to intradermally injected nicotine for exclusion of the diagnosis of leprosy. After the Congress both travelled on the continent for several weeks, visiting hospitals and clinics and making random observations of the various socialized medicine plans to be found there. Dr. Arnold, Jr., gave an illustrated talk on leprosy before the dermatology staffs in Strasbourg and Munich and visited skin clinics also in Edinburgh, London, Amsterdam, Padua, Geneva, Paris, and Ann Arbor.

**Dr. Andrew L. Margan** announces the opening of his offices at 305 Royal Hawaiian Avenue. Dr. Morgan attended Punahou and Iolani Schools in Honolulu. He had a year's fellowship at St. John's University, Shanghai, and received his B.S. degree from Dartmouth. He attended Cornell University Medical School at New York City. He interned for one year at Lenox Hill Hospital, New York City. Following this internship he spent two years in the Medical Corps of the Army and had overseas duty in the Philippines and New Guinea. He was a surgical resident at Queen's Hospital for over two years and a resident on the genito-urinary service at Newington Veterans' Hospital in Connecticut. Dr. Morgan is limiting his practice to urology.

**Dr. Shayei Yamauchi** was elected Fellow of the American College of Surgeons.

**Dr. and Mrs. Paul Withington** announce the arrival of a daughter, Elizabeth Little, born on October 13, 1952.

To the Editor:

I am happy to be able to report that I just passed the oral examination of the American Board of Internal Medicine. The reason I am submitting this for possible inclusion in your Notes and News is its relationship to the residency training program at Queen's. I believe I am the first one to pass any Board who received all his clinical training at Queen's. (I satisfied part of the 3 year formal training requirement with 9 months of pathology at Michael Reese Hospital, Chicago.)

I hope this will help to serve as incentive to the present residents to help make the most out of their residency training program; the philosophy that one only gets in proportion to what one puts in holds in every situation. I trust the success of one of their students gives some measure of satisfaction to those doctors who gave so freely of their time to us residents.

If possible, please thank especially Drs. Arnold, Sr., Beck, Bell, Berk, Doolittle, Fujiwara, Giles, Gotshalk, Hartwell, Okazaki, Perlstein and Walker.

San Francisco, Sept. 19.

S. Richard Horio, M.D.

**Dr. Richard K. C. Lee,** Assistant Health Executive, Territorial Department of Health, recently returned from the WHO's Second Western Pacific Regional Conference at Saigon, French Indo-China. Dr. Lee acted as an observer for the Territory of Hawaii and adviser to the United States delegation to the Conference.

**Dr. N. P. Larsen** returned from a four months' trip to the Mainland and Europe. While in Sweden, Dr. Larsen gave addresses at several universities.

Back from the Mainland are **Dr. R. C. Dusendschon, Dr. G. C. Freeman, Dr. H. E. Bowles, Dr. Lyle Phillips, Dr. Donald Depp, Dr. R. O. Brown, Dr. Laurence Wiig, Dr. Garton Wall, Dr. Thomas Bennett** and **Dr. Douglas Murray.**

**Dr. George Hill Hodel** of the staff of the Territorial Hospital at Kaneohe was recently married to Miss Hortensia Laguda.

**Dr. Clarence E. Fronk** and **Dr. Ralph B. Cloward,** armed with gun and camera respectively, left on a safari which is to include Tanganyika, British East Africa, Nairobi, Tabore, New Delhi, Kashmir, etc.

**Dr. H. Y. Ing** announces the association of his son **Dr. Kenneth Ing** in the general practice of medicine and surgery at 43 So. Kukui St. Dr. K. Ing is a graduate of Temple University at Philadelphia. He interned at St. Francis Hospital in Peoria, Illinois, and also spent one year there in surgical residency under the University of Illinois. Dr. Ing is married and has one child. He is now working part time at the Emergency Hospital.

**Capt. Raymond J. Mansfield,** M.C., U.S.N., recently assumed duties as Senior Medical Officer at the New York Naval Shipyard, Brooklyn, New York. Capt. Mansfield spent fifteen years in Hawaii prior to joining the regular Navy in 1941.

Friends of **Dr. and Mrs. Louis Gaspar** eagerly look forward to Louis' fascinating letters sent from various points of interest along their trip. In their last letter from Innsbruck, Austria, we find that from the tropic heat of India they are now facing the snow-capped Alps.

**Dr. Richard W. You,** who served as physician to the U. S. Olympic Team in Helsinki last summer, was awarded a license by the Territorial Boxing Commission to manage boxers.

**Dr. Robert Kimmich,** clinical director of the Territorial Hospital for the past year, has been named medical director of that institution. He filled the vacancy caused by the death of **Dr. Marcus Guensberg** on July 11. Prior to his arrival in the Territory, Dr. Kimmich was assistant chief of Neuropsychiatry at Newington Veterans' Hospital. Before this he served as psychiatric instructor at Yale University School of Medicine.

**Dr. C. V. Caver,** for the past two years medical director and superintendent of the Kalaupapa Settlement, Molokai, has resigned to enter private practice in Wahiawa in association with **Dr. J. P. Lucas.** Dr. Caver is a graduate of the University of Texas. He served his internship at Queen's Hospital and served in the Navy from 1946-1948. He then became a member of the Southwestern Medical Foundation at Dallas, Texas, and later trained in dermatology at the University of Pennsylvania Graduate School of Medicine in Philadelphia.

**Dr. Robert M. Browne,** resident in psychiatry at Queen's Hospital, was married to Miss Mieko G. L. Morimoto of Hilo and Honolulu on August 8, 1952. Dr. Browne received his B.S. degree from the University of Rochester, New York, and his M.D. from Johns Hopkins University School of Medicine in Baltimore.

**Dr. and Mrs. John C. Milnor** announce the arrival of their first child, a daughter, born September 3.

**Dr. Gail G. L. Li** announces the opening of his offices for the practice of obstetrics and gynecology at 56 So. Kukui Street. Dr. Li is a graduate of Punahou and Jefferson Medical College, Philadelphia. He served his internship at Queen's Hospital and a two year residency at Kapiolani Maternity Hospital. He then left for Detroit where he spent six months in the Herman Kiefer Hospital and then 18 more months as senior resident in gynecology at the Detroit Receiving Hospital. For a year he was the trainee of the National Cancer Institute where he became head of the gynecological cancer division.

**Dr. George Benjamin Garis** was married to Miss Margaret Jean Bolte at Central Union Church on October 18, 1952. Dr. Garis is a graduate of the University of Virginia School of Medicine. He is with the Straub Clinic.

## MATSUJU YAMASHIRO, M.D.
## 1897-1952

Dr. Matsuju Yamashiro died in Honolulu on August 18, 1952, of acute myocardial infarction, at the age of 55. He is survived by his widow, Mrs. Namiko Yamashiro, a daughter, Naomi Miyoko, and two sons, Roy Akio and Kenneth Matsuji.

Born in Okinawa in 1897, Dr. Yamashiro came to Hawaii in 1912 at the age of 15. He graduated from McKinley High School, and in 1930, having taken his premedical work at Cornell College and Iowa State College, graduated from Iowa State Medical School. He interned at St. John's Hospital in Iowa, following which, in 1931, he returned to Honolulu.

He began his practice here at 156 North Kukui St. After six years of practice he returned to Japan for a year's postgraduate work at Keijo Medical College.

Dr. Yamashiro was keenly interested in medical conditions on his native island of Okinawa. He became vice president of the Okinawa Medical Relief Association in 1946. In 1950 he went to Washington to discuss Okinawa's medical problems. In the following year he returned to Okinawa as a member of a party whose mission was to distribute drugs there.

In addition to his professional duties, Dr. Yamashiro had a financial bent which led to his becoming vice president of the Cooperative Finance Company in 1950, and also the auditor of the Hawaii Economic Study Club.

## Kauai

The Kauai County Medical Society welcomes a newcomer to the Garden Island. He is **Dr. Richard Yamauchi,** recently from Honolulu. He substituted for **Dr. Wallis** during his brief vacation and then for **Dr. Fujii.** He is expected to be the Plantation Physician for Grove Farm.

Recent island visitors were **Dr. and Mrs. Leonid Zavosky,** formerly of Puumaile Hospital.

**Dr. Fujii** left for a two months' vacation in Japan. From newspapers we note that he is doing quite well in golfing.

### Hawaii

**Dr. Richard Knotts** has replaced Dr. Edwin Willett at Naalehu.

**Dr. and Mrs. Richard Yamanoha** are the proud parents of a baby girl, Michelle Merrill, born on September 21.

A son, Eric Ken, was born to **Dr. and Mrs. Robert Miyamoto** on September 22. Another Junior medic.

**Dr. S. Mizuire** recently returned from the mainland following a graduate course in surgery in New York City.

## NEWS

### Polio Fellowships

The National Foundation for Infantile Paralysis announces the availability of a limited number of post-doctoral clinical fellowships in physical medicine and rehabilitation to candidates who wish to become eligible for certification in that field.

In addition to these full-term fellowships, the National Foundation is making available a limited number of short-term fellowships to physicians who, in addition to meeting the other requirements, have completed a minimum of one-year residency in orthopedics, pediatrics, neurology or internal medicine.

Complete information concerning qualifications and applications on both types of fellowships may be obtained from the Division of Professional Education, the National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y.

### The International Academy of Proctology 1952 Award Contest

The International Academy of Proctology takes pleasure in announcing its Annual Cash Prize and Certificate of Merit Award Contest for 1952-1953. The best unpublished contribution on Proctology or allied subjects will be awarded $100.00 and a Certificate of Merit. Certificates will be awarded also to physicians whose entries are deemed of unusual merit.

All entries are limited to 5,000 words, must be typewritten in English, and submitted in five copies. All entries must be received no later than the first day of April, 1953. Entries should be addressed to the International Academy of Proctology, 43-55 Kissena Blvd., Flushing 55, New York.

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# UMI MAKAHIKI I HALA*

**Dr. Frederick Giles, Dr. Edmund Ing** and **Dr. Leslie Luke** have been called to active duty with the Army Medical Corps.

**John Milnor** and **Andy Morgan,** sons of Dr. and Mrs. Guy C. Milnor and Dr. and Mrs. James A. Morgan, graduated from Dartmouth on May 10 and have entered the medical schools of Temple and Cornell, respectively.

**Dr. L. Fernandez,** formerly with the Honolulu Plantation, went to Hawaii in August to become associate physician at Pepeekeo Hospital with Dr. Thomas Keay.

From make-shift and widely scattered quarters, the Honolulu Blood Bank moved in August into a building of its own, constructed especially for it on the grounds of The Queen's Hospital. The O. C. D. provided the funds to construct the building.

**Dr. William Ito,** member of Queen's Hospital staff, has recently been appointed to take over the Palama Settlement venereal disease clinic, replacing **Drs. Edmund Ing** and **John Devereux.**

In spite of the uncertainty attending returns to Hawaii under military regime, several of our physicians have taken the chance and made trips to the mainland. Among these were **Dr. Pinkerton, Dr. Haralson, Dr. Edes Alsup, Dr. Spencer, Dr. Holmes, Dr. Mitchell, Dr. Gaspar, Dr. Mossman.** Dr. Gaspar enjoyed working his way back on a cattle boat.

**Dr. Francis D. Nance** has joined the Medical Group.

**Dr. Alfred S. Hartwell** has recently been appointed Medical Director for Queen's Hospital. Dr. Hartwell comes from an old kamaaina family. He is a graduate of Harvard Medical School.

**Dr. and Mrs. Colin McCorriston** returned recently from Boston. Dr. McCorriston has joined the Clinic's department of obstetrics.

The much needed new quarters for the Mental Health Clinic at Queen's Hospital have been completed, providing ten additional clinic beds and office space for the entire staff. This addition was made possible from O. C. D. funds.

The Japanese Hospital will no longer be known by that name; it is now the Kuakini Hospital.

**Major C. L. Wilbar,** M.C., U.S.A., has been appointed County Health Officer for Maui County with headquarters in Wailuku.

**Dr. Douglas Murray** reports from one of the outposts that he is having a swell time fishing. He makes his rounds in a hat and shorts and a jeep.

**Dr. Rodney West,** somewhere in the Pacific, is trying to compose another Desert song. Someone sent him a piano and he's quite content.

**Dr. Wm. F. Leslie,** formerly of the staff of Leahi Home, has arrived in Hilo and assumed the Superintendency of Puumaile Home.

* Ten years ago. From Volume II, Number 2, November-December, 1942.

# "...A SENSE OF COMFORT AND CHEERINESS"



"In my years of accounting work I audited several hospitals and installed systems at several. I have never found one that approached the Nursing Home for all around excellence. Personnel relations are superb, with close coordination and cooperation from top to bottom.

"Above all, the place is clean and neat as a pin and gives one a sense of comfort and cheeriness.

"You the Directors and the Administrator are to be congratulated in making such a fine facility available to the community."

(Signed)
W. L. Lawrence

Mr. Lawrence is a Certified Public Accountant and the auditor of the Home. His letter points up one of the basic purposes of this institution—to provide "a sense of comfort and cheeriness"—both prime factors in convalescent progress.

In a superb setting, the Convalescent Nursing Home is ideally situated for its purpose—within a 20-minute drive from downtown Honolulu. Its rates, as low as $5.50 per day, make its facilities suitable to a wide range of patients.

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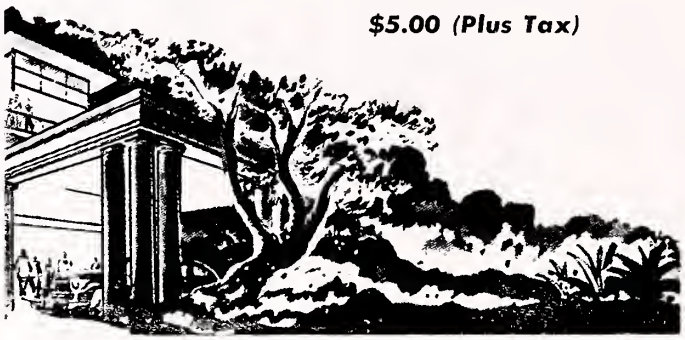
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***Children's Portion Half Price***

SAMPAN BAR




**PRIVATE PARTIES UP TO 45 IN THE FO'C'SLE**

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAM, *Executive Secretary,* Honolulu

BULLETIN COMMITTEE

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## PRESIDENT'S ADDRESS

When the Nurses' Association, Territory of Hawaii, was incorporated October 25, 1918, thirty-four years ago, it was established "for benevolent and fraternal purposes, especially for the purpose of maintaining a code of ethics for nurses, furthering all means aiming to elevate the standard of the nursing profession; and to promote the general welfare of members of the nursing profession." New aspects of these objectives are brought into prominence each year.

During the last year we have participated with the Hawaii League of Nursing Education and the Territorial Board for the Licensing of Nurses in the study of the new civil service categories for both the practical and professional nurse, as set up by the Research Associates for the Board of Salary Standardization. The Board of Directors attended one of the public hearings in April 1952, and in June we filed, by letter, a statement of objection concerning the educational requirements of nurses, work categories, etc. In August we sent a statement requesting that all professional categories be raised at least one level.

In cooperation with our sister organization, a special committee was appointed to study the field of scholarships available for nurses. The Commission on Nursing Service and Nursing Education will give the results of their further study and have available these facts.

In June your Association sponsored a tea honoring the completion of plans for the University School of Nursing. The first class of student nurses embarking on this four year degree program will enter the University this fall. This is a real milestone in the history of nursing in Hawaii. You are to be congratulated for your share in making this possible.

Upon receipt of the auditor's report for 1951, the legal transfer of the Nursing Service Bureau and Physicians' Exchange was completed. Since April 1952, this has been under the sponsorship of the Nurses' Association, District of Oahu.

Some of the long range program anticipated has been impossible to accomplish this year. We are still very eager to work out a plan whereby our Executive Secretary may have an office which she does not necessarily have to share. Many working hours are wasted in our present arrangement. Miss Adam has been very patient with the inconveniences she has had to accept.

We have been working on plans whereby our Margaret Jones Memorial Fund will be handled in a more businesslike manner. Since 1950 four loans have been made amounting to $2,100; many older loans have never been paid. With assistance from the Board, the Committee is working out better procedures for loans, etc. They will give you the complete report. After seeking advice as to our best procedure for managing our finances, your Board of Directors voted to have the Bishop Trust Company handle all our finances. This will include the collecting of loans for Margaret Jones Memorial Fund, auditing, paying of bills, etc. This puts our organization on a firmer business

basis with maximum protection. Our securities will be cared for and a safety deposit box is no longer needed.

The greatest worry of the last year has been the lack of response to membership enrollment. With the decrease of membership dues, our budget has been in a critical condition. It had been my hope that as I handed over the gavel to our new president, I could also hand over a sound financial, smooth running organization. We have worked hard to reach this goal for you. Hours and days have been spent searching old records in order to clear up questions about financial responsibilities. We have completed our search for ANA Relief Funds. We find that part of these funds were deposited in the Mabel Smyth Memorial Fund and part in the Margaret Jones Memorial Fund. We can now clear our record with ANA. Several of us have spent hours "cleaning house." An up-to-date, almost complete file is now available in which may be found our auditor's reports dating back to 1926. We have not been successful in finding an auditor's report for the year of 1935.

Our financial security rests in your hands. Our budget deficit can be met only if you and I are interested in meeting the goal—that of 1035 professional nurses as members of their organization. Economic security can be obtained only as each nurse interests herself in *her own group* advancement through membership in her nurses' association and activity in her section. I believe that some of our sections will be officially organized at this annual meeting.

As professional nurses we need to encourage the organization of practical nurses' associations on each island. As a Big Sister organization, we need to lend a guiding hand in their growing years of infancy.

We need to promote better nursing care through better personnel policies. It is important that we as a group also realize our responsibilities in giving our best in return. Let us remember that good public relations must be our aim.

We also need to develop more leadership. Group participation through committee work is an excellent experience. Satisfaction of a job well done makes you a more secure person.

I want to express my appreciation to Miss Leona Adam, our Executive Secretary, for her untiring assistance in helping us to accomplish those objectives for which we have striven. To each member who has helped me during my term as President, may I also say thank you. Without your spirit of service and willingness to work, we could not have advanced as far. I am happy for having had the opportunity of serving you in this capacity.

As a challenge for the coming year, let us accept "A Work Creed" by Charles Dawes.

"If you work in a profession, in Heaven's name work for it. If you live by a profession, live for it. Help advance your co-worker. Respect the great power that protects you, that surrounds you with the advantages of organization, and that makes it possible for you to achieve results. Speak well for it. Stand for it. Stand for its professional supremacy. If you must obstruct or decry those who strive to help, why—quit the profession. But as long as you are part of a profession, do not belittle it. If you do, you are loosening the tendrils that hold you to it and with the first high wind that comes along you will be uprooted and blown away and probably you will never know why."

Your President,
ARLENE N. THOMPSON

## COMMITTEE REPORTS

The following are excerpts abstracted from various committee and representative reports, which were submitted to the Executive Secretary, NATH, prior to their presentation at the Annual Convention, October 27, 28, 29. They, of course, will have been available "in toto" to members who attended the meetings; however, it seemed that some brief follow-up was in order, toward the end of bringing into sharper focus the association's major activities for the year 1952, and also to provide a convenient résumé for those unable to attend the convention.

Reports of the delegates at the Biennial Convention have been omitted since the material is available in the national nursing journals.

### Finance Committee

The following budget for 1953 has been proposed and presented to the Board of Directors:

*Expected Income:*

| | |
|---|---|
| 700 active members at $9.00 per capita* | $6,300.00 |
| 100 associate members | 150.00 |
| Total | $6,450.00 |

*$11.00 per member has been retained in NATH budget in the past. The Board has attempted to absorb the $2.00 raise for ANA, hence only $9.00 is now retained in budget.

| | |
|---|---|
| *Expenses:* | $9,466.00 |
| *Deficit:* | 3,016.00 |

*Recommendations* proposed to meet deficit:

(1) Increase in membership: 335 additional active members above 700 would raise income to $9,465.00.
(2) Increase in dues: from $9.00 to $14.00 per active member x 700 would yield $9,800.00.
(3) Large fund raising project.

Bernadette Nakahata, Chairman

### Constitution and By-Laws Committee

This committee and the office secretary have labored hard and long since the Biennial Meeting in order to

have the proposed revisions in members' hands one month before the annual meeting. The proposals are in line with the revisions made in the ANA by-laws by the House of Delegates at the Biennial. They have been accepted by the NATH Board and have been sent to the membership.

Mabel Snyder, Chairman

## Legislation Committee

Because this is not a legislative year, the committee has not been very active.

The committee recommends:

1. That the House of Delegates of the Nurses' Association accept as its legislative program the legislative recommendations made by the Commission on Nursing Services and Nursing Education after thorough study of the survey on nursing needs in the Territory done by Miss Ruth Gillan of the Federal Security Agency.
   a. Full development of the University of Hawaii School of Nursing.
   b. More scholarships for the preparation of local nurses for supervisory, instructional and administrative positions in the field of nursing.
   c. Appropriations for the Practical Nursing School sufficient for adequate housing, equipment and staff, which will make it possible to enlarge the student body, lengthen the course to one year and continue the two year evening extension program for employed practical nurses who have not had the advantages of formal training.
   d. Creation by the legislature of additional positions for professional and practical nurses, especially in the psychiatric hospital at Kaneohe which is critically understaffed.
   e. Continuation of the Commission on Nursing Services and Nursing Education.
2. That districts and/or sections devote at least one meeting to legislation, inviting senators and representatives to discuss legislation.

Lillian Jonsrud, Chairman

## Membership Committee

A goal of 800 members for 1952 was set by the Association. The committee met on six occasions to discuss means to increase membership; these, in turn, were passed on to district committees for action. A potential membership goal was set for each district. Publicity, membership awards, personal contact with non-members to urge joining the association, individual invitations to new graduates, letters to hospital directors of nurses requesting their cooperation in urging membership of all staff nurses, etc., were some of the devices employed. Present status is 569 active and 69 associate members.

Ann Burley, Chairman

## Counseling and Placement Service Committee

The Counseling and Placement Service Committee spent some time becoming oriented to the program as it is being conducted. Problems were discussed with the counselor upon her request and as she was unable to obtain a list of child caring institutions, this list with information regarding each was compiled for her by the committee. Often nurses are unable to work because they cannot find satisfactory care for small children. Counseling and placement is much more than mere placement of nurses in positions!

Dorothea McClintic, Chairman

## Library Committee

The Library committee has assumed the following responsibilities:

1. To determine means of making the library more useful to nurses.
2. To obtain suggestions for, select and order new nursing books and periodicals.
3. To list newly obtained books and periodicals for publication in INTER-ISLAND NURSES' BULLETIN.
4. To select reviewers and books for review to be published in the NURSES' BULLETIN.
5. To recommend policies in relation to maintenance and use of the library.

A contribution of $500.00 obtained from the Margaret Jones Memorial Fund made possible authorization of the following:

1. Binding—two volumes of *American Journal of Nursing* and nineteen volumes of *Public Health Nursing*.
2. Subscription to *Nursing Research*, new periodical published by ANA.
3. Purchase of 16 books and pamphlets selected from suggestions made by representative nursing groups.
4. Purchase of pamphlet files.
5. Requests to 100 universities for catalogues of their nursing schools.

Thus far in 1952, six book reviews have been obtained and published. Arrangements have been made with the library staff to provide an accessible shelf for nursing periodicals, and means devised to make nursing material more readily available. Policies have been formulated and recommended for adoption by NATH for use and maintenance of nursing material in the library.

Virginia Jones, Chairman

## Board of Management, Mabel Smyth Building

Mrs. Illa Storme was appointed Building Manager following the resignation of Miss Jessie Eyman.

Plans are being considered for enlarging the building in order to accommodate the present occupants more adequately. Doctors and nurses will be solicited for contributions; however, other fund raising methods are being studied. A special Building Committee composed of the Board of Management with representatives from Medical and Nurses' Associations, and Woman's Medical Auxiliary, is being formed.

Ine Higa, Representative

## Committee on Survey and Assignment of Health Personnel, Territorial Civil Defense

This committee is made up of representatives from the associations of persons with any kind of medical or health training. Its functions are to determine the needs of such personnel in event of disaster, to recruit and to assign the personnel according to needs.

The committee has sent out questionnaires to all registered professional and practical nurses and to all people suggested by the other associations, regarding their availability.

Consideration is being given to setting up neighborhood first aid centers for assigning and training personnel in working teams.

Virginia Jones, Representative

### Oahu Health Council

Ten programs on important community health problems have been presented, such as housing and slum clearance in Hawaii, mental hygiene of infancy and childhood, changing problems in tuberculosis control, fluoridation of water supply, free medical care, chronic illness, narcotics and venereal disease in Hawaii, and trends in cancer control.

A prize-winning documentary film, "Angry Boy," was shown during Mental Health Month.

At the annual meeting Senator Wilfred Tsukiyama spoke on "Your Senator Looks at Health."

Ine Higa, Representative

### Citizens' Council on Narcotics Control

Several meetings were held to discuss the organization and methods which would serve best in attacking this problem. An executive committee, a coordinating committee, and several special project committees were established.

The NATH representative became a member of the Committee on Treatment and Rehabilitation. Following a visit to the Territorial Hospital at Kaneohe to study facilities for the treatment of narcotic addicts, this committee reported that:

a. Narcotic patients are not segregated from other patients.
b. Addicts frequently dismiss themselves following only a few weeks of care.
c. Our laws at the present do not provide for confinement of such patients, therefore they can leave the hospital at any time.
d. There is a desperate need for a separate unit for such patients and for more personnel. This has been referred to the Council's Legislative Committee for action.

Following discussion and research regarding the possibilities of obtaining a scholarship and sending a nurse and a social worker to the mainland for special work in the treatment of the narcotic addict, it was decided that perhaps it might be better to arrange a series of local workshops for interested agencies and individuals to help them to understand more fully the various aspects of the problems of the narcotic addict. Further consideration is being given this possibility for late fall.

This committee feels that the narcotics problem should not be stressed in the schools as a separate unit but should be a part of the entire area of mental hygiene. A printed primer on the narcotics problem is being considered.

Wilma Porter, Special Representative

### Scholarship Committee, Honolulu Chapter National Foundation for Infantile Paralysis

The Hawaii Chapter of the National Foundation for Infantile Paralysis awards scholarships on an individual basis to applicants interested in training in the following areas: orthopedic nursing, communicable disease nursing, public health nursing, nursing education, physical therapy, health education, medical social work, psychiatric social work, anesthesia, occupational therapy, vocational rehabilitation, sanitary engineering, public health statistics, bacteriology, virology, postgraduate medicine and brace making.

Since September, 1951, scholarships have been granted to nurses as follows:

a. Miss H. Baker, to complete her degree in nursing education at Pacific Union College.
b. Public health nurses, Mrs. S. Medeiros and Mrs. Y. Izumo, were each awarded $75 to attend a refresher course in poliomyelitis.
c. Mrs. M. Alexander of Maui attended the summer session at the University of Washington to study nursing supervision and education.
d. Miss Rose Hee was recently awarded a $1,000 scholarship for a program of study in nursing supervision and administration.

On November 5, 1951, nursing representatives met with Miss Carolyn Kingdon, Executive Secretary of the Honolulu Chapter of the National Foundation for Infantile Paralysis, to discuss available scholarships for nurses through the Chapters. The group felt there was a need, (1) for some study regarding numbers and types of scholarships available in the Territory and (2) for dissemination of such information to the nurses. The question was raised as to whether it might be helpful to have an over-all clearing committee within the Nursing Association to screen nursing applicants. No conclusions were drawn as to how such a committee would be established and function. At the present time the Commission on Nursing Services and Nursing Education is compiling information on scholarships available to nurses locally as well as those offered from a national level.

Currently the Honolulu Chapter is not considering new applications for scholarships until the termination of the epidemic of polio because of possible depletion of funds.

Paula Sorg, Representative

## DISTRICT REPORTS

### Hawaii District Nurses' Association

This has been an active and successful year due to much hard work by many members.

Some of the highlights of the year were the delegates' report on the Territorial Nurses' Association Convention; talks on China and the West Indies by Dr. Edward Wong and Mr. William Channel respectively; the institute on disaster; 25th anniversary dinner, honoring the charter members, with Miss Leona Adam, Executive Secretary, as guest speaker; institute on poliomyelitis, and the selection of a delegate to the Biennial Convention in Atlantic City, Miss Clara Mitchell.

Elizabeth Stillman, President

### Kauai District Nurses' Association

Kauai District Nurses' Association reports 46 active members and 16 associate members, only 5 members short of the quota set by NATH Membership Committee.

Programs during the year covered refresher courses and lectures on some phases of Atomic Nursing. A two-day Institute on Atomic Nursing was held with Mrs. Rosie Kim Chang and Dr. Dorian Paskowitz as moderators and speakers. As a result of this project and an intensive drive to enlist the cooperation of various community agencies, a Civil Defense Health Program for the County of Kauai has been developed.

The Scholarship Committee made three awards this year which brings the total number of students in nursing schools to six, the first of whom will graduate in 1953. A highly successful rummage sale, netting $734.00, as well as contributions from members of the medical profession, made possible the third award.

E. H. Middleton, President

## Maui District Nurses' Association

Membership, educational programs and opportunities, participation in community activities, and a project for raising funds were major points of emphasis in this year's program.

As for membership, out of a total of 116 professional nurses in Maui County, 69 are now active members and 19 associate members, an increase of 8 active and 9 associate members from the previous year.

An Institute on Poliomyelitis was held. The Association participated in planning and presentation of a program in conjunction with the territorial and local chapters of the National Foundation for Infantile Paralysis. As a result more nurses are prepared for polio nursing, community interest has been aroused, and funds were procured to buy equipment.

Interest in educational opportunities continues. Several attended University of Hawaii Extension Courses on Maui: Mrs. Okuni Tanner, PHN, the three weeks "Family Life" Workshop at the University of Hawaii; Mrs. Margaret Alexander, PHN, advanced work in PHN at the University of Washington.

The problem of Civil Defense has been considered and plans for specific work in this area are to be formulated.

Representatives have been present at many community agency and organization meetings, and at special events.

Funds to carry on association activities have been raised through weekly sales of sweet bread.

Gloria Foster, Acting President

## Oahu District Nurses' Association

Five meetings have been held. Total attendance 689, or a rough average of 158 each. Two meetings were held jointly with Hawaii League of Nursing Education and one with the Cancer Society. Programs presented by Oahu District: Annual Meeting, Disaster Nursing, Film and Discussion, "Feelings of Hostility," "Orphans of the Past" (Community Theater Players), Compulsory Membership.

Membership quota was not met. Current standing is 407 active and 26 associate members. Institutional group is area lowest in membership. Several hospitals are arranging with their professional staffs for payroll deductions, dues to be accepted on an installment basis, payable in three installments.

Esther Stubblefield, President

## AMERICAN RED CROSS NURSING SERVICES

During the past fiscal year Nursing Services has accelerated the home nursing program in order to strive to achieve the goal of one trained home nurse in every family. With the help of interested professional nurse and non-nurse volunteer instructors, 1,473 persons were trained in Home Care of the Sick and Injured technics during the 1951-1952 fiscal year; 1,458 persons were trained in Mother and Baby Care and Family Health; and 71 Volunteer Nurse's Aides completed the 80 hour training course. This fiscal year, 109 instructors were trained to teach Red Cross Home Care of the Sick and Injured, and Red Cross Mother and Baby Care and Family Health throughout the Territory, on Molokai, Hawaii, Kauai, and Oahu. A total of 3,108 persons were trained in 211 classes to care for themselves and others in the event of illness in the home, or in time of natural or war-caused disaster. This figure is more than one-third gain over the 144 classes and 2,216 persons trained in the Territory during the 1950-1951 fiscal year.

During the fiscal year professional nurses earned Red Cross Nurse badges by participating in the nursing services volunteer program, bringing the total enrollment to 481. The roster of enrolled Red Cross nurses is invaluable to Hawaii Chapter during a local disaster when need for professional nurses develops without warning.

Four hundred and six professional nurses completed the 1952 Poliomyelitis Nurses Institutes on Maui, Oahu and Hawaii. Poliomyelitis Nursing Institutes were cosponsored by the Hawaii League of Nursing Education; the Honolulu Chapter of the National Foundation for Infantile Paralysis, and branch chapters, and the Hawaii Chapter of the American National Red Cross.

Red Cross nurses in the Territory of Hawaii gave 6,406 volunteer hours to 25 special nursing projects other than home nursing and volunteer Nurse's Aide instruction during the fiscal year. Red Cross nurses manned the first aid stations at the county and state fairs, assisted with the immunization program on Kauai, manned the respirator demonstration for the March of Dimes campaign, served at the Kiddy Carnival, and as camp nurses on Kauai and Oahu, as well as on other special projects.

A total of 161 home nursing instructors gave 3,325 volunteer teaching hours to Red Cross Nursing Services during the past fiscal year. Ninety per cent of the home nursing classes were taught on a volunteer basis.

Isabel M. Medeiros, Representative

## PERSONAL NOTES

Miss Eileen McHenry was recently awarded a Master's Degree in Industrial Nursing from Yale University Graduate School, and has resumed work with Maui Pineapple Company. She attended the Biennial Convention in Atlantic City and acted as a delegate for the Territory.

Miss Dorothy Sakamoto received her B.S. Degree in Nursing from the University of Pittsburgh recently, and has returned to Queen's Hospital as clinical nursing instructor. She, too, attended the Convention as a delegate for the Territory.

Baccalaureate degrees in Nursing were awarded the following nurses at the University of Hawaii during 1952: Mary Jane Krantz, Joy Schock, Janet Toda, Clara Ishikawa, Marion Kwock, Sally Nakano, Doris Shiroma, Violet Yamashiro, Thelma Yap, Rachel Todd, and Mary Nailau. All awards were in Public Health Nursing except that of Mary Jane Krantz's, which was in Nursing Education.

Word has been received from Mrs. Arlene Thompson who is presently working to complete graduate study in Guidance and Counseling at Denver University. She wished to express appreciation for the Aloha gift presented on behalf of the Nurses' Association, and to remind the group that though absent from the scene she anticipates with eagerness news of our activities and progress.

## ACTIONS OF YOUR BOARD OF DIRECTORS

August 15, 1952—Full Board. Met 3:30 to 6:00 p.m. and 7:30 to 10:30 p.m.

**Voted** to send letter to the administrative heads of the Territorial Department of Institutions and the Department of Health regarding the recommended pay grades for nurses in the Gallas report. See BULLETIN issue September-October, 1952, for copy of letter. (Copies were later sent to the members of the Salary Standardization Board.)

**Accepted** report of the Committee on Nominations. (See elsewhere in this issue.)

**Approved** minutes of Board meeting held July 18, 1952.

**Heard** the treasurer's report.

**Discussed** and **accepted** as corrected the proposed revisions of the by-laws as presented by the Chairman of the Constitution and By-Laws Committee.

**Discussed** obligations of membership to subscribe to the INTER-ISLAND BULLETIN. When the Medical Association assumed responsibility for this publication, it was with the understanding that the BULLETIN would be purchased by the total membership. If this subscription was made voluntary, either the cost of the JOURNAL would become almost prohibitive or the Medical Association would probably discontinue publication of the INTER-ISLAND NURSES' BULLETIN.

**Voted** to employ Bishop Trust Company to handle all of NATH's financial business, including the Margaret Jones Memorial Fund. (This will amount to about a forty dollar per year saving as compared to the separate accounting and auditing procedure which we now have, but most important, it will mean a smoother functioning business routine with a clearer picture for the association of its financial status. The Trust Company will also act as consultants on financial problems.)

**Voted** to send a representative to the Economic Security Workshop held by ANA in Omaha, Nebraska. (Since Sister Jolenta, already on the mainland, was unable to attend, her alternate, Mrs. Lois Bell, will go. ANA will pay transportation, but Mrs. Bell will pay her own living expenses.)

**Voted** that the President appoint a special committee to draft a platform for the Nurses' Association, Territory of Hawaii.

## WELCOME WAGON

The Welcome Wagon, Inc., is interested in knowing about nurses who are engaged, have new babies, have boys and girls who reach their sixteenth birthdays, who move from one part of the town to another or who may be celebrating some unusual event.

The hostess will call on you and present you with a basket of merchandise, contributed by local merchants. We have been assured there is no high powered selling connected with this program.

If you qualify in one of the above categories and desire a visit from a Welcome Wagon hostess, please telephone the Nurses' Association office—telephone number 52-2255.

## ANNOUNCEMENT

Information regarding courses in and related to nursing is available on file in the Nursing Section of the Mabel Smyth Library, Mabel Smyth Building.

## CONVENTION NEWS

If you weren't there you really missed something; fun—nurses proved themselves to be "next to" professional dancers, models, actors, radio speakers and singers; interesting discussions on ANA program, economic security, overweight and budgetary items; good food at the poi luncheon and the dinner at the Moana; favors —interesting nurse place cards made by the students of the three schools of nursing, matches, blotters, woodrose corsages, cigarettes, and pocketbook calendars; two movies—one on weight control and one on the Biennial in Atlantic City; exhibits on travel, nurses in the news, Biennial and structure; and most important of all, contact with Miss Ella Best, our gracious and well-informed Executive Secretary from ANA.

Skits by Kauai and Maui pleading for the 1953 convention might have ended in a draw except that the new president is located on Maui so Kauai generously moved to have the first "off Oahu" Convention on Maui. So let's get ready for Maui next year!

**Highlights of the Business Meetings:**

Raise of dues for Nurses' Association, Territory of Hawaii, from seventeen dollars to eighteen dollars. However, the dollar paid the last two years to ANA for the nursing function studies is to be taken out of the two dollars ANA raise in dues.

Margaret Jones Memorial Fund was voted to be a trust fund with the Bishop Trust Company as trustees.

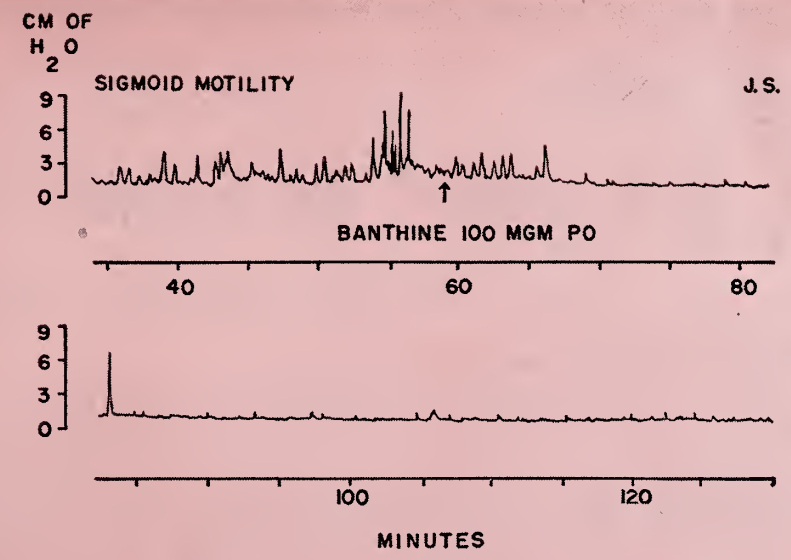
In the Professional Counseling and Placement Service a fee is to be charged for the collection of credentials for nurses who are not members of ANA.

A resolution was passed recommending the forty hour job.

An appeal was made for contributions to the building fund of Mabel Smyth Memorial Building so that additional space can be added to provide more adequate quarters for organizations using the building.

**Congratulations** and best wishes to the new Hawaii League for Nursing. This was voted into being and by-laws accepted. Officers: President—Alison MacBride, R.N., Vice President—Sister Laurine, R.N., Secretary—Sister Marie Therese, R.N., Treasurer—Sara Jane Trainovich, R.N. Directors: Myrna Campbell, R.N., Dr. John Devereux, Dean Wilfred J. Holmes, Virginia Jones, R.N., Mrs. Guy N. Rothwell, Myrtle Schattenburg, R.N.

New officers for Nurses' Association, Territory of Hawaii: President—Mrs. Elizabeth McCall, R.N., 2nd Vice President—Mrs. Margaret Makekau, R.N., Treasurer—Mr. Lawrence Katsuyama, R.N. Director from Hawaii—Miss Moira Wilson, R.N., Director from Oahu —Mrs. Flora Ozaki, R.N.




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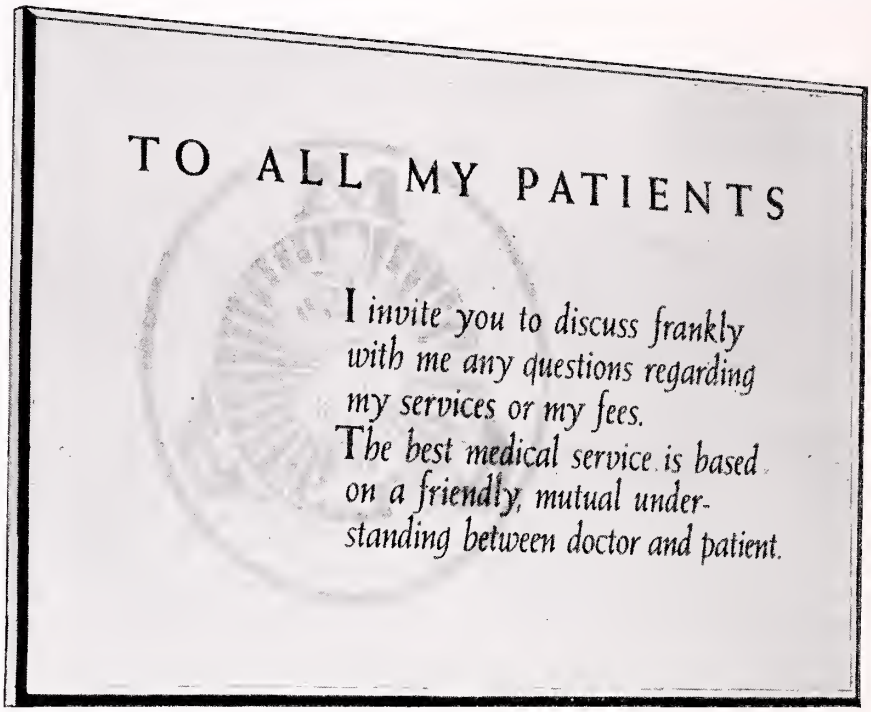
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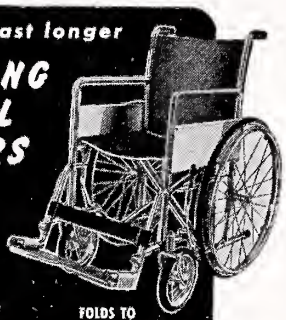
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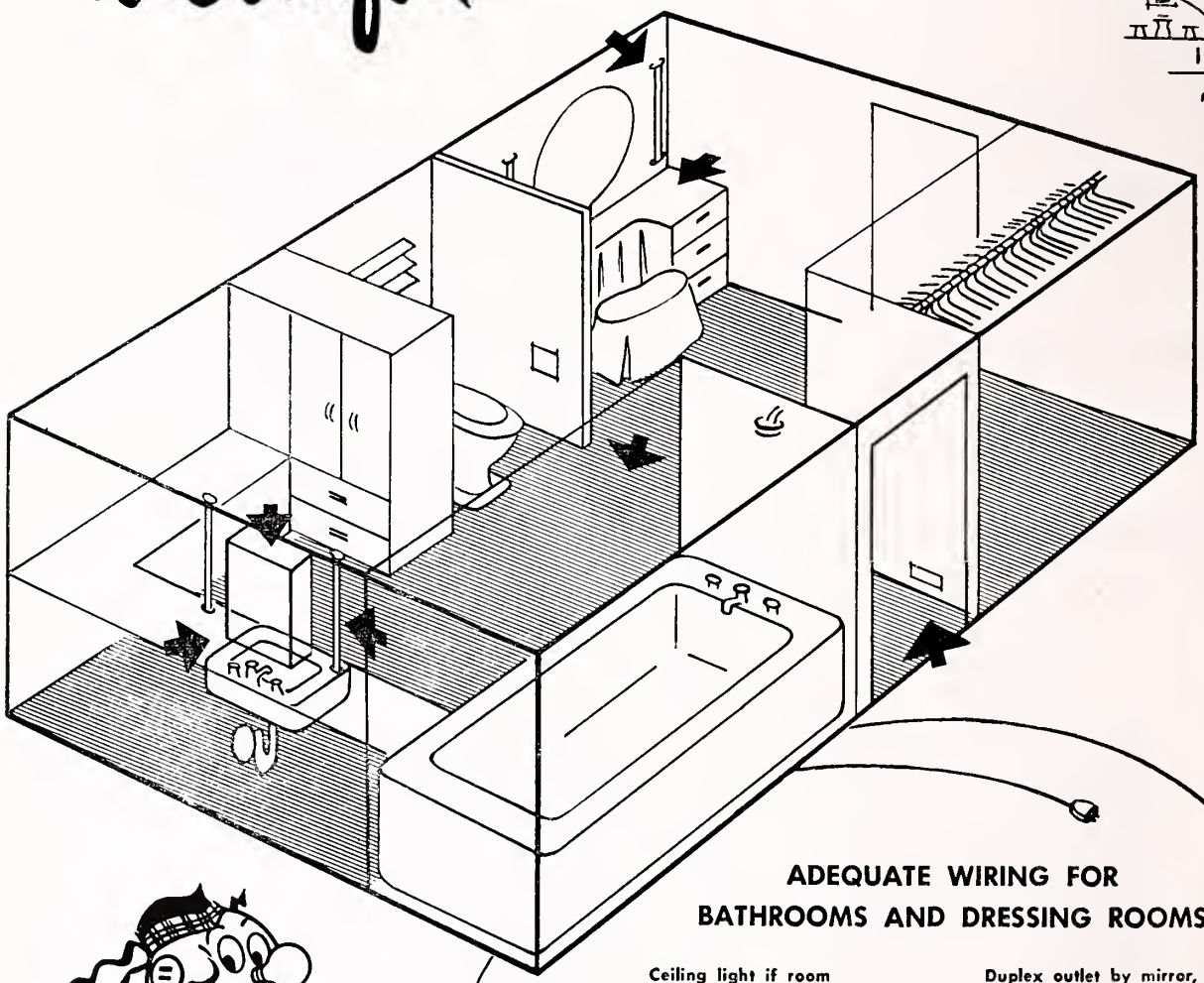
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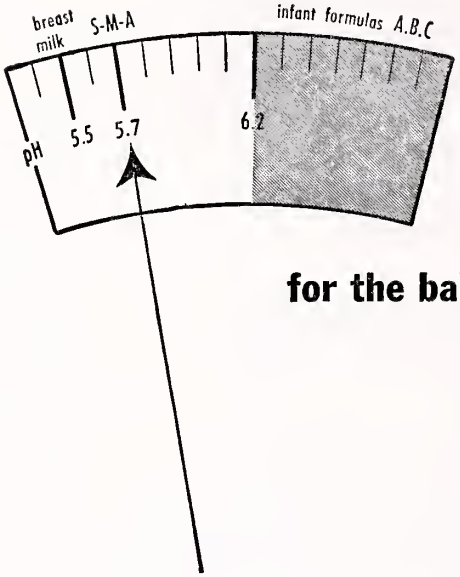
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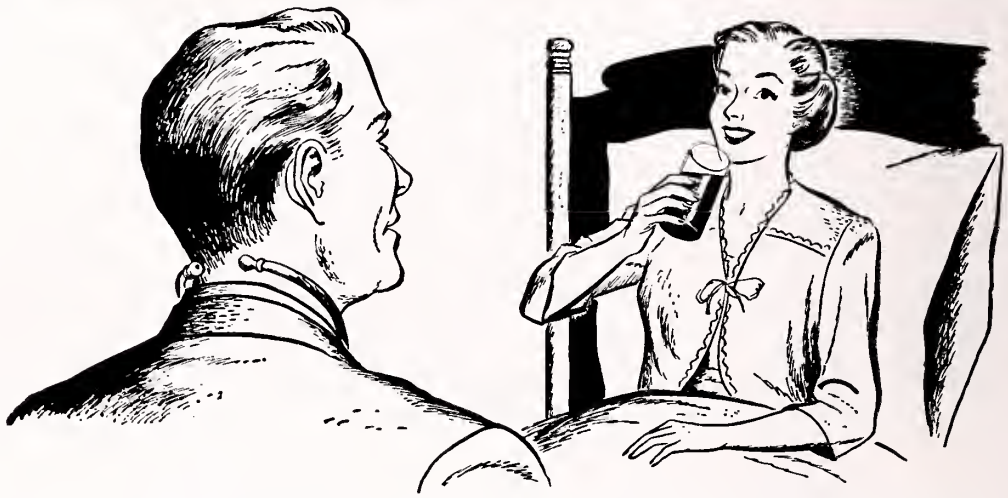
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# WHEN DRUG THERAPY

## Increases Nutrient Requirements



The administration of many drugs can sharply increase the patient's requirements for various essential nutrients. The presence and action of certain drugs in the organism may alter normal utilization of nutrients to purposes of detoxication of these drugs.

In some instances, drugs may impair absorption of nutrients, increase their destruction within the digestive tract, interfere with their metabolism, or hasten their elimination. With prolonged administration, therefore, unless the intake of various nutrients is increased, deficiency states may be precipitated.

The dietary supplement Ovaltine in milk can significantly increase the nutrient intake of the patient when therapy makes this adjustment necessary. As shown by the table below, it provides substantial amounts of all nutrients known to be essential. Its excellent quality protein furnishes an abundance of all the indispensable amino acids.

Because of its delicious flavor, Ovaltine in milk is universally enjoyed by patients. It is easily digested, bland, and its nutrients are quickly available for utilization. The two varieties of Ovaltine, plain and chocolate flavored, both similar in high nutrient content, allow choice according to flavor preference. Children particularly like Chocolate Flavored Ovaltine.

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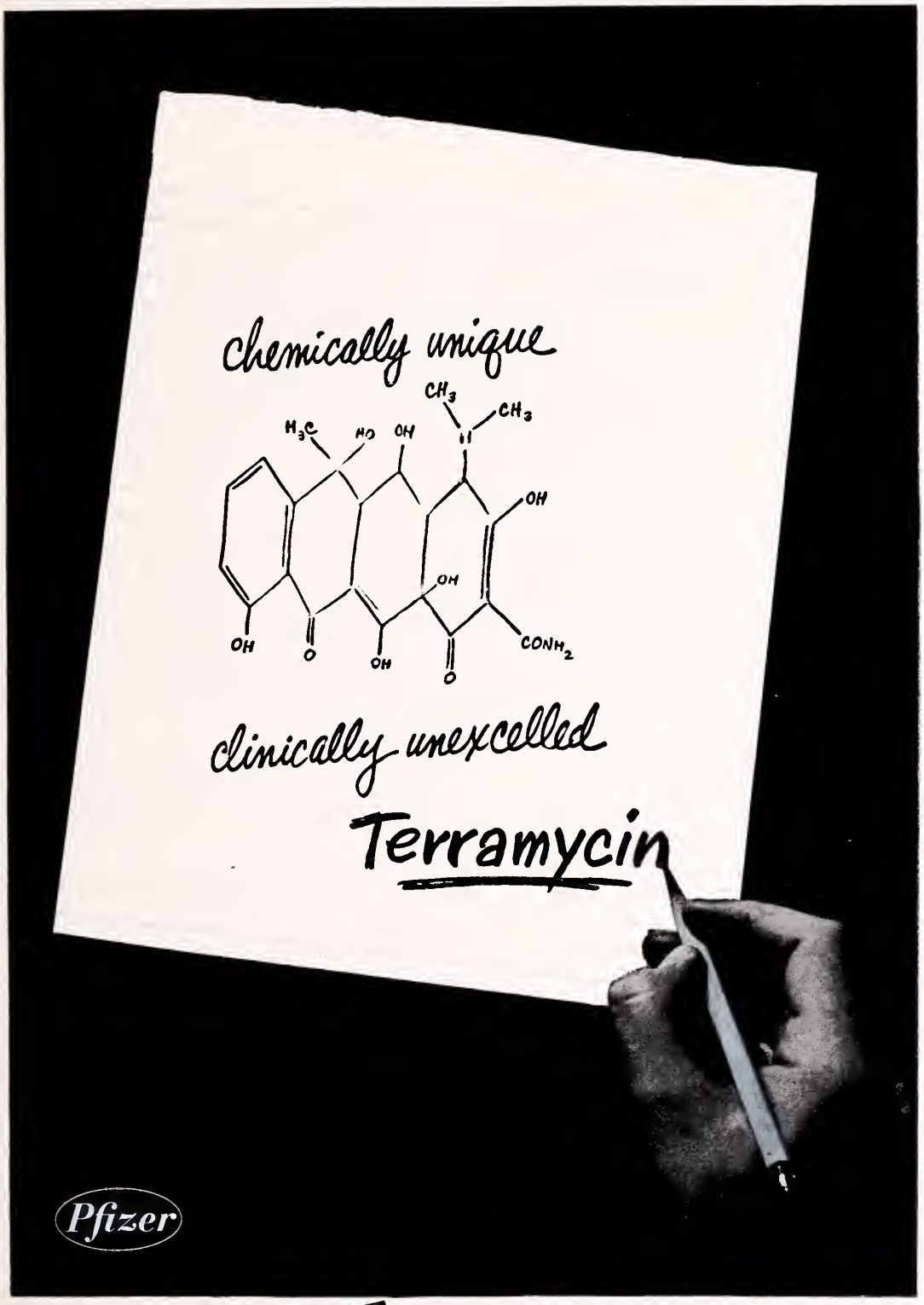
**Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients**

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

| MINERALS | | | | VITAMINS | | | |
|---|---|---|---|---|---|---|---|
| *CALCIUM | 1.12 Gm. | MAGNESIUM | 120 mg. | *ASCORBIC ACID | 37 mg. | PYRIDOXINE | 0.6 mg. |
| CHLORINE | 900 mg. | MANGANESE | 0.4 mg. | BIOTIN | 0.03 mg. | *RIBOFLAVIN | 2.0 mg. |
| COBALT | 0.006 mg. | *PHOSPHORUS | 940 mg. | CHOLINE | 200 mg. | *THIAMINE | 1.2 mg. |
| *COPPER | 0.7 mg. | POTASSIUM | 1300 mg. | FOLIC ACID | 0.05 mg. | *VITAMIN A | 3200 I.U. |
| FLUORINE | 3.0 mg. | SODIUM | 560 mg. | *NIACIN | 6.7 mg. | VITAMIN $B_{12}$ | 0.005 mg. |
| *IODINE | 0.7 mg. | ZINC | 2.6 mg. | PANTOTHENIC ACID | 3.0 mg. | *VITAMIN D | 420 I.U. |
| *IRON | 12 mg. | | | | | | |

*PROTEIN (biologically complete).....32 Gm.
*CARBOHYDRATE.....65 Gm.
*FAT.....30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.




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*Migraine In Children*

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

| NO. OF CASES | SEX | AGE AT ONSET | CYCLIC VOMITING | DURATION OF ATTACK | INTENSITY |
|---|---|---|---|---|---|
| 31 | 8 ♀ 23 ♂ | 3 yrs. (mean) | 3 out of 31 | 2½ hrs. | severe in all cases |

TABLE CONT'D

| NO. OF CASES | UNILATERAL HEADACHE | NAUSEA | FLIMMER SCOTOMA | VERTIGO | HEREDITY |
|---|---|---|---|---|---|
| 31 | 18 out of 31 | 31 out of 31 | 12 out of 31 | 6 out of 31 | 20 out of 31 |

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

These criteria are useful in diagnosis:

Headache attacks with symptom-free intervals plus (at least two of the following) nausea, scintillating scotoma, hemicrania, and hereditary predisposition.

**For symptomatic relief in these cases, Cafergot®, N.N.R. (ergotamine with caffeine) may be administered orally. For best results, give adequate dosage promptly.**

For children within the age range 7 to 12 years—Cafergot® is administered, one tablet when the attack appears imminent followed by one additional tablet within 30 minutes. Not more than two Cafergot tablets should be administered to children within this age range.

In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. *(Total maximum dose for adults: six tablets for each attack.)*

*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

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*Adams, C. H., and Cecil, R. L.: Ann. Int. Med. *33*:163, 1950.

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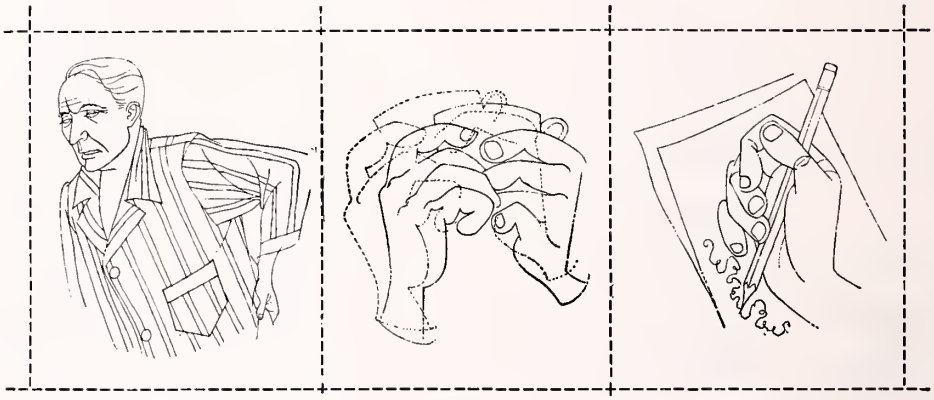
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Sharp & Dohme, Philadelphia 1, Pennsylvania.

1. J.A.M.A., 127:330, 1945. 2. J.A.M.A., 128:9, 1945.

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The first dose prescribed should be at the lower end of the recommended dosage range *(an occasional patient may complain of side effects when* large *doses are given at the* start *of Tolserol therapy).* Subsequent doses may be adjusted to the needs of the individual patient. Whenever possible, Tolserol should be given after meals. When Tolserol is given between meals, it is desirable that the patient first drink ⅓ glass of milk or fruit juice.

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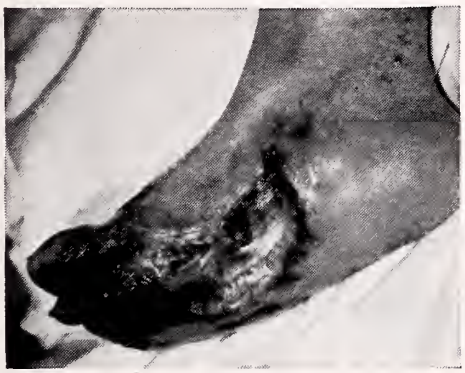
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*Downing, J. G. et al.: J.A.M.A. 133:299, 1947. Shipley, E. R. et al.: Surg. Gynec. & Obst. 84:366, 1947. Wawro, N. W.: Connecticut M. J. 12:17, 1948. McCollough, N. C.: Indust. Med. 16:128, 1947. Long, P. H.: A-B-C's of Sulfonamide and Antibiotic Therapy, Philadelphia, W. B. Saunders, 1948, p. 152. Meyer, J. H.: J. Internat. Coll. Surg. 13:748, 1950.

*Literature on request*




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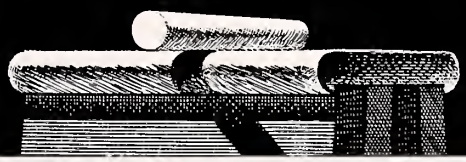
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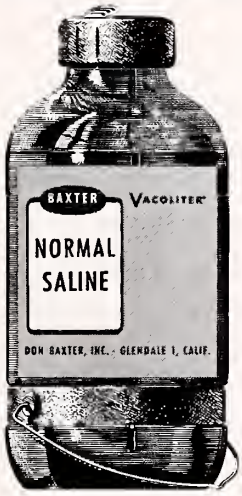


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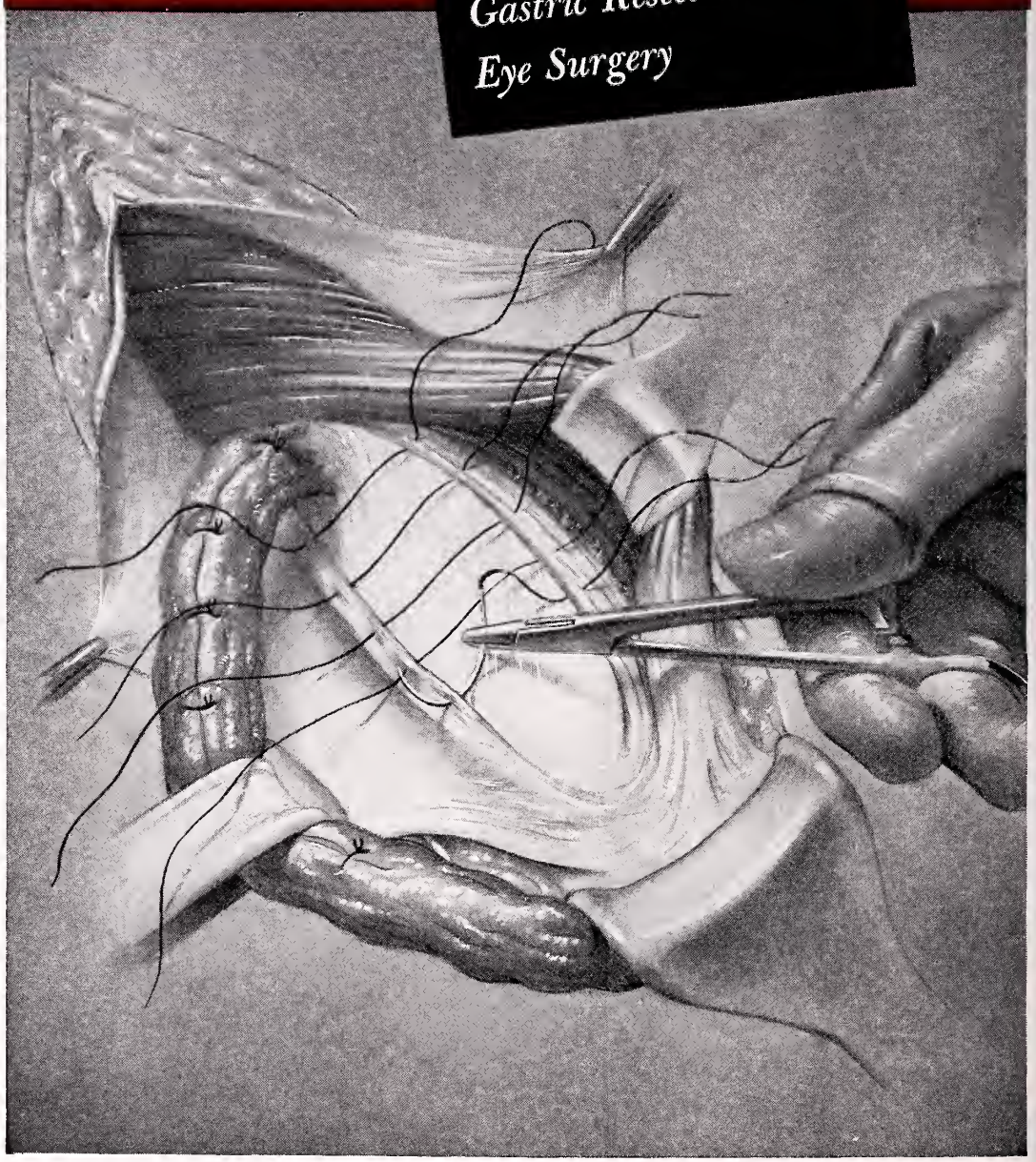

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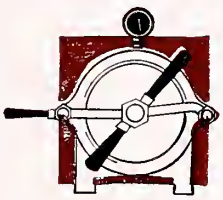
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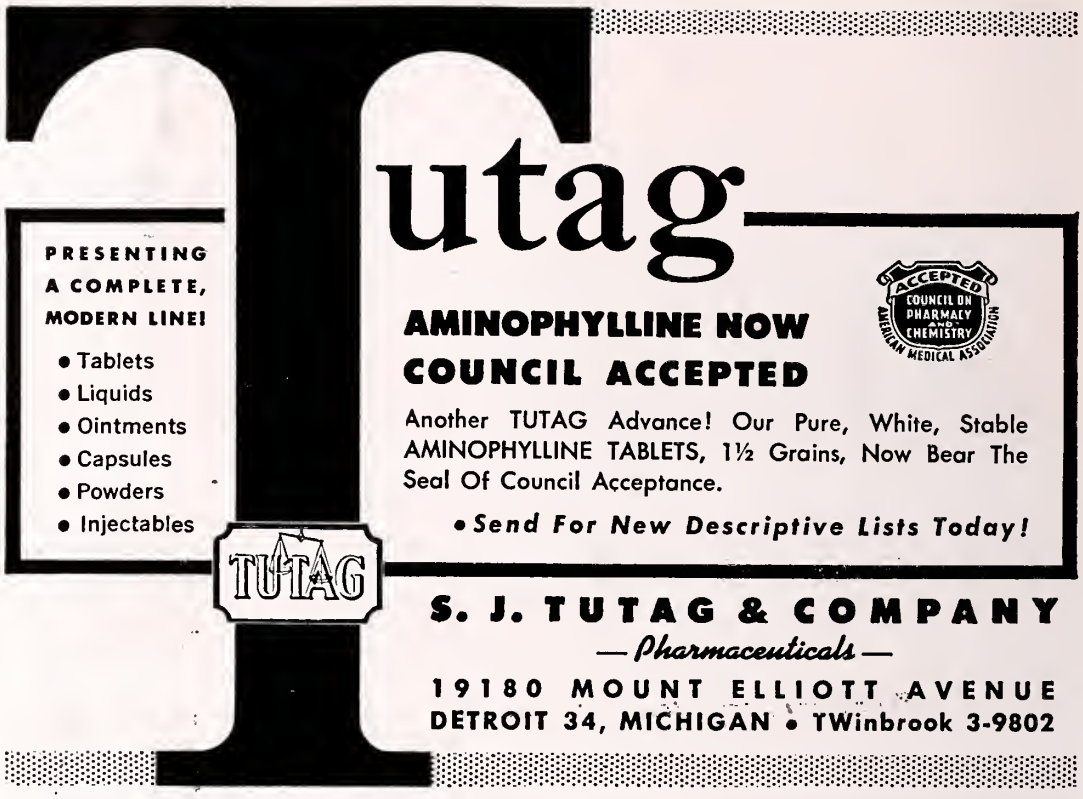
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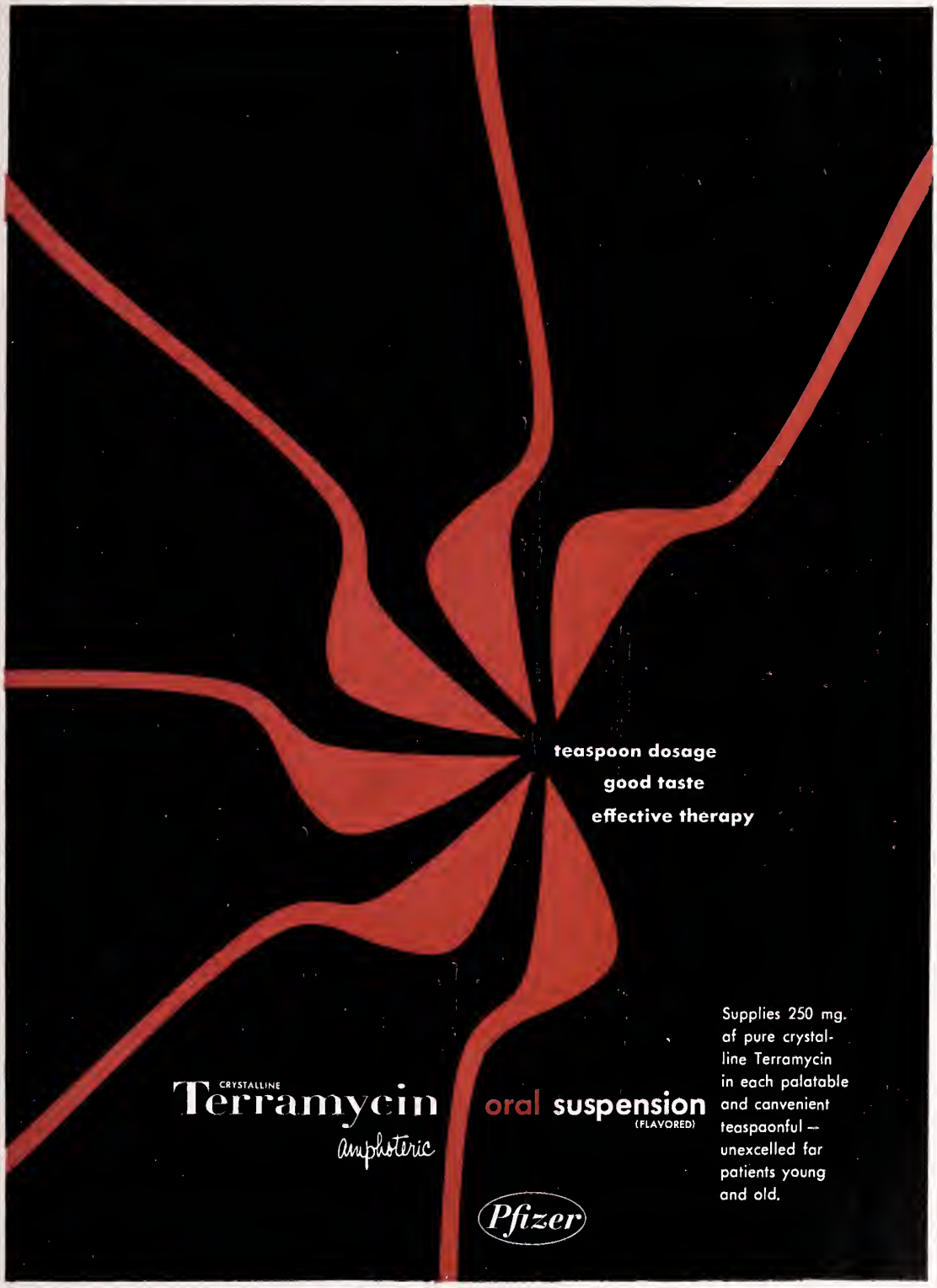
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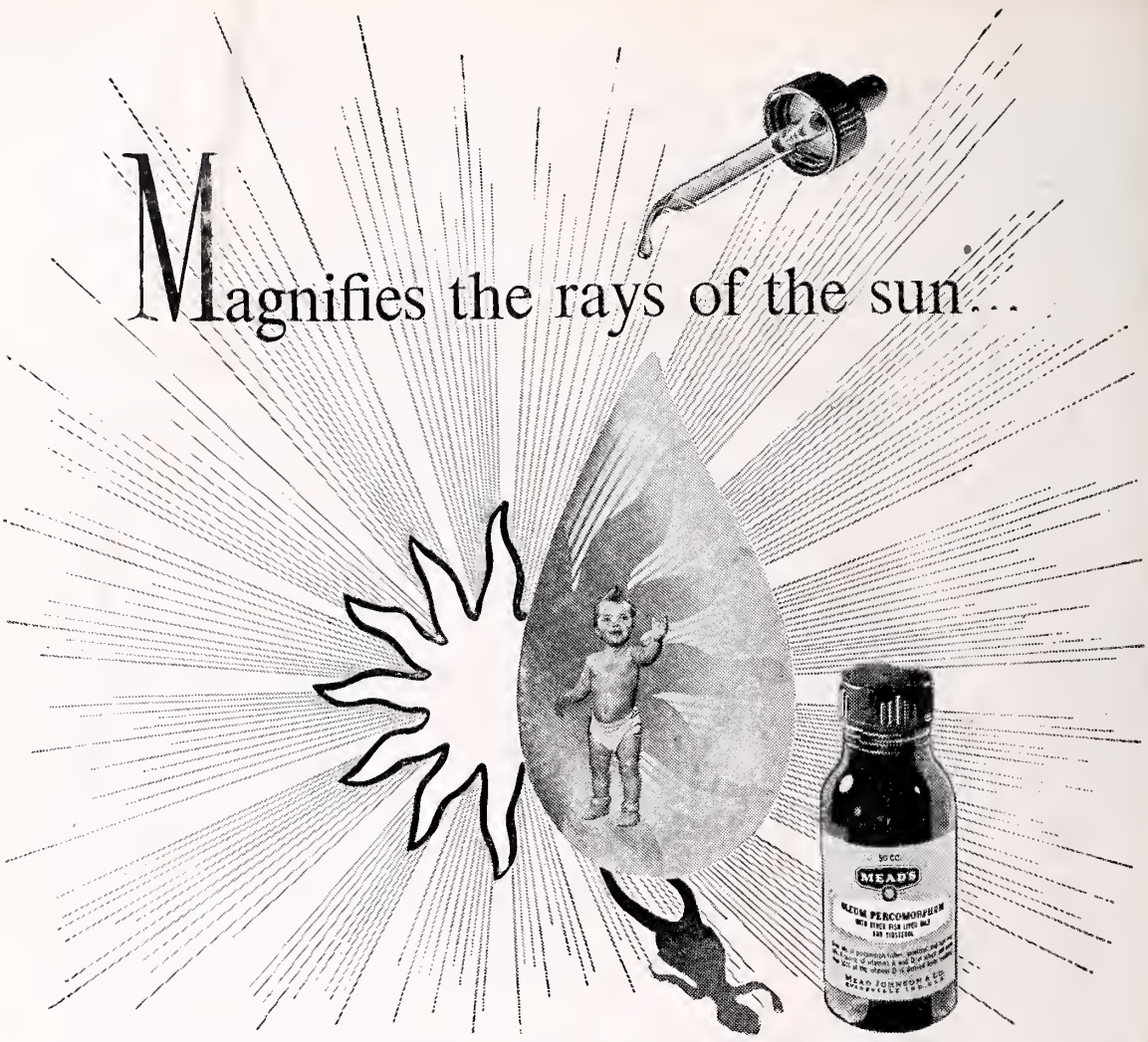

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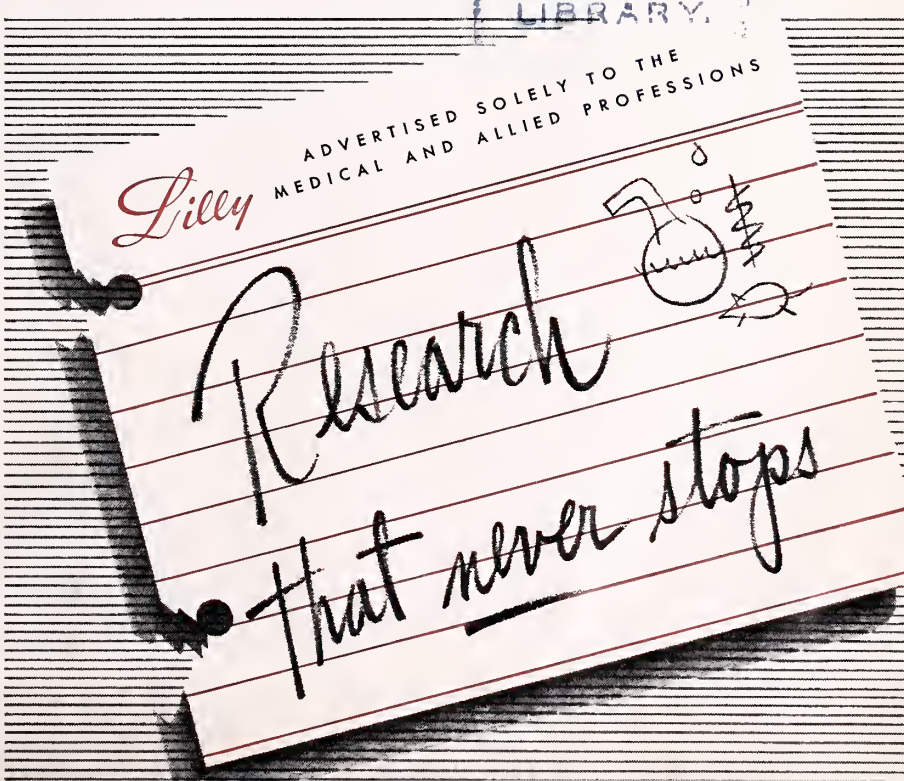
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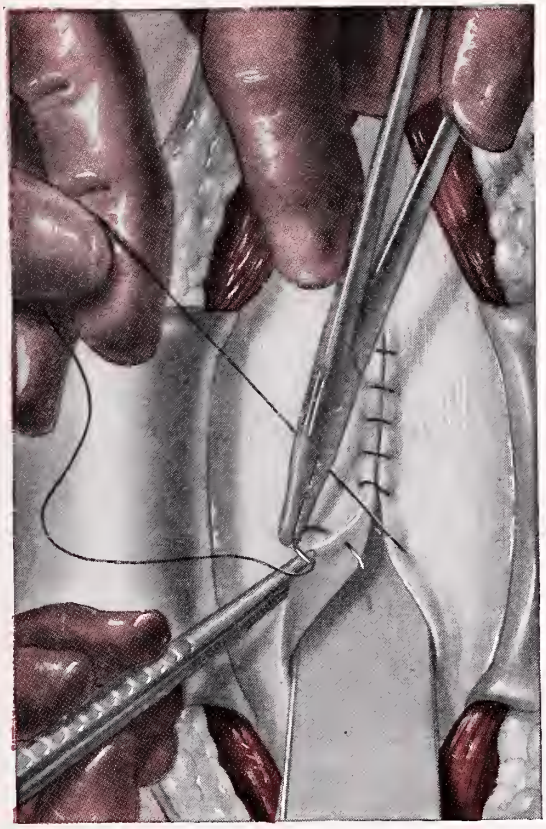
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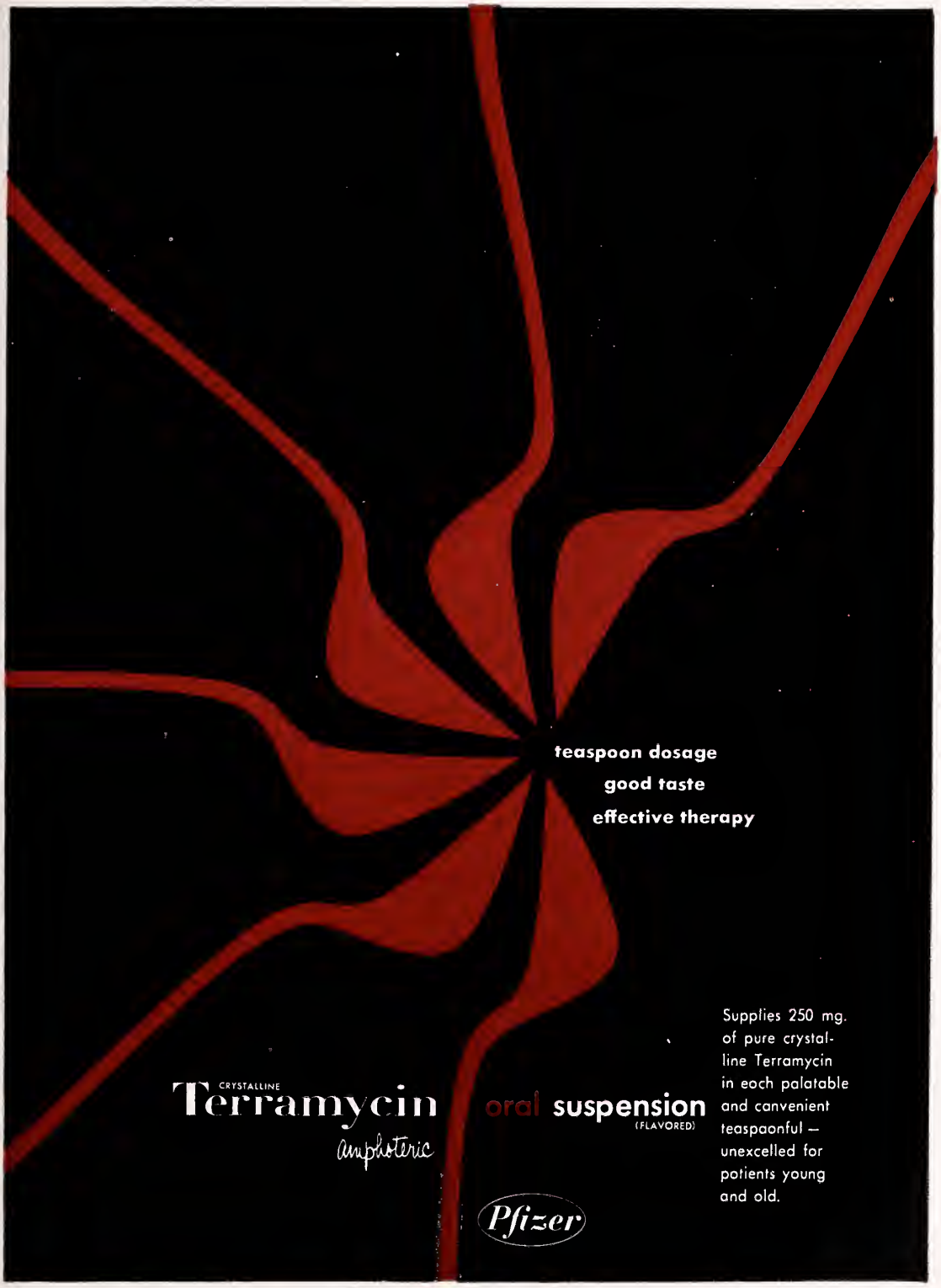
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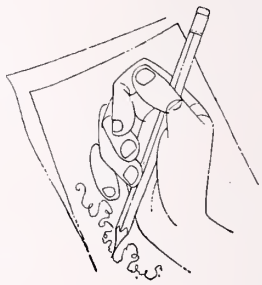
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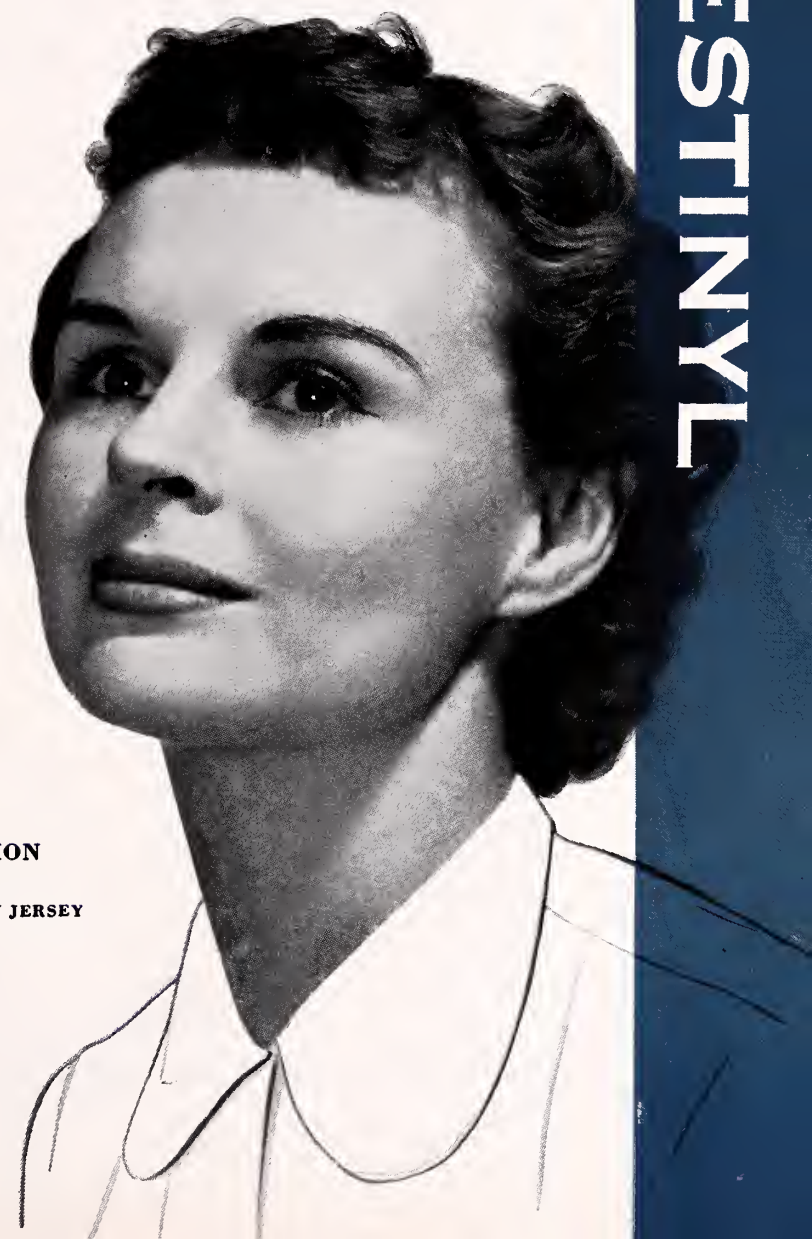
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Induces gradual and sustained reduction of blood pressure with no dangerous, abrupt fall on oral administration.

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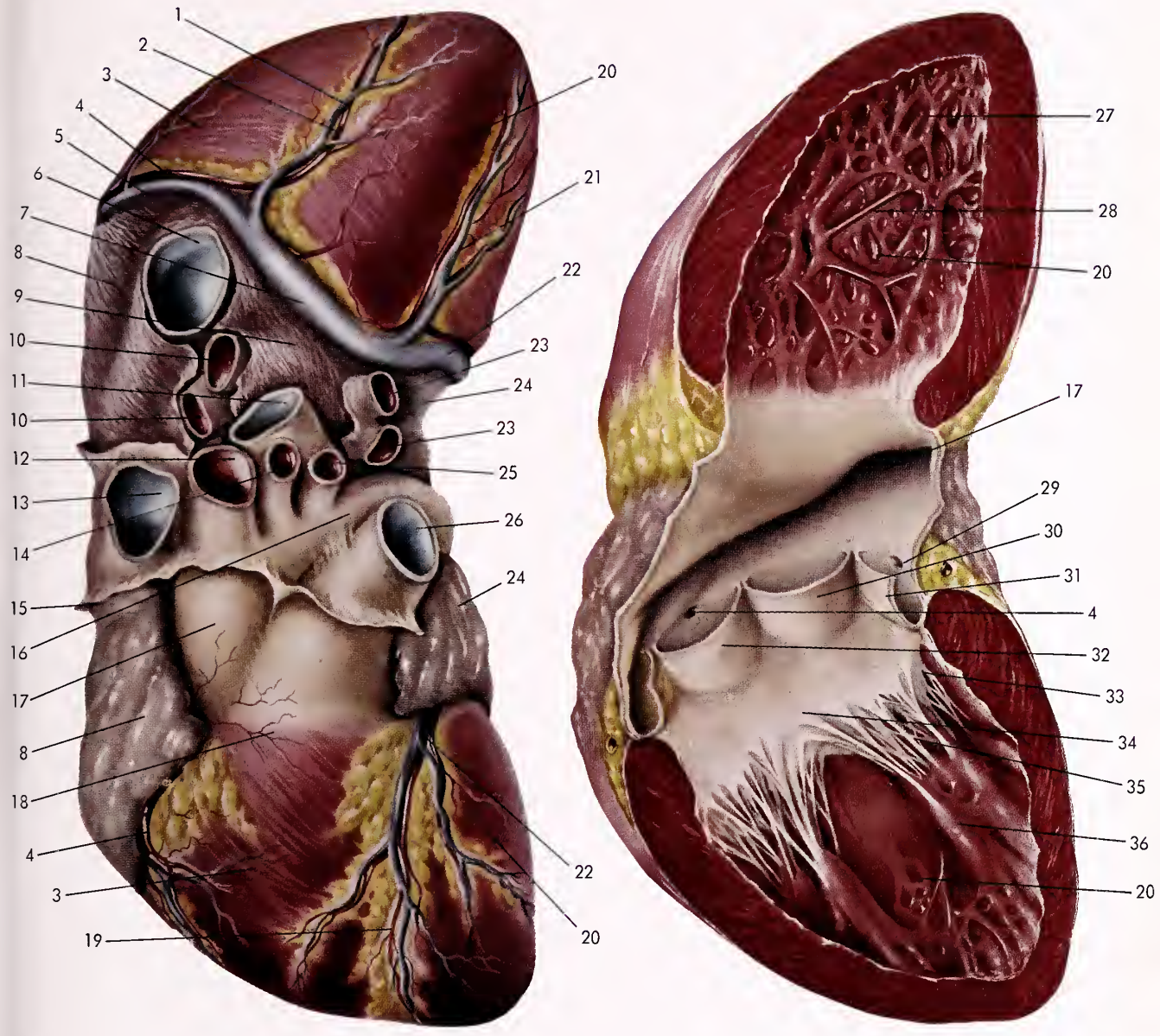
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2/1884M

# Anatomy *of the* Heart




1 Middle cardiac vein
2 Posterior descending branch of right coronary artery
3 Right ventricle
4 Right coronary artery
5 Small cardiac vein
6 Inferior vena cava
7 Coronary sinus
8 Right auricle
9 Left atrium
10 Right pulmonary vein
11 Right branch of pulmonary artery
12 Innominate artery
13 Superior vena cava
14 Left common carotid artery
15 Pericardium
16 Aortic arch
17 Ascending aorta
18 Conus arteriosus
19 Anterior descending branch of left coronary artery
20 Left ventricle
21 Posterior vein of left ventricle
22 Great cardiac vein
23 Left pulmonary vein
24 Left auricle
25 Left subclavian artery
26 Left branch of pulmonary artery
27 Trabeculae carneae
28 Trabecula tendinea
29 Left coronary artery
30 Posterior semilunar valve
31 Left semilunar valve
32 Right semilunar valve
33 Posterior cusp of mitral (bicuspid) valve
34 Anterior cusp of mitral (bicuspid) valve
35 Chordae tendineae
36 Papillary muscle

*This is one of a series of paintings by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.*

# Aureomycin

HYDROCHLORIDE CRYSTALLINE

## *in*

## *Infections Involving the Heart*

ENDOCARDITIS—Aureomycin has established itself as one of the most valuable agents available for the treatment of infections involving the heart. Aureomycin is now recognized as a highly effective antibiotic against the organisms most frequently encountered in endocarditis—staphylococci, *Str. viridans*, *Str. fecalis* and other enterococci. These organisms are being increasingly found resistant to penicillin and streptomycin. Endocarditis caused by these organisms has responded to aureomycin after failure of other antibiotics. Aureomycin is held by many physicians to be an antibiotic of choice for prophylactic use in patients with organic cardiac disease who require oral, intestinal, or rectal surgery, or any transurethral operative procedure. Endocarditis complicating typhus and brucellosis has responded well to aureomycin therapy.

PERICARDITIS—The importance of aureomycin in pericarditis has been demonstrated by its successful use after failure of other therapy—in acute nonspecific pericarditis, possibly of viral etiology; *H. influenzae* pericarditis; tularemic pericarditis; and actinomycotic pericarditis.

RHEUMATIC FEVER—Because aureomycin is an antibiotic with a wide range of effectiveness against the pathogenic strains of streptococci, its use has been recommended for the prevention of acute rheumatic fever and its cardiac complications.

* * *

PACKAGES: *Capsules:* 50 mg.–Vials of 25 and 100; 100 mg.–Vials of 25 and bottles of 100; 250 mg.–Vials of 16 and bottles of 100. *Ophthalmic Solution:* Vials of 25 mg.; solution prepared by adding 5 cc. distilled water.

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**5. Cattle bred from champions such as the one pictured above are distributed to local dairy farmers to improve the quality of the milk supplied to Carnation processing plants.**




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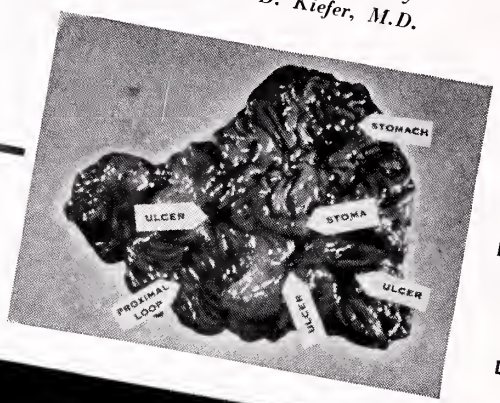
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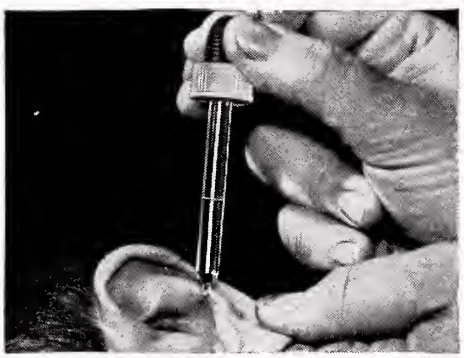
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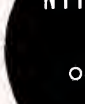
— marked diminution in the malodor of chronic otitis media.

*Anderson, J. R. and Steele, C. H.: Laryngoscope 58:1279 1948. Douglass, C. C.: Laryngoscope 58:1274 1948. Long, P. H.: A-B-C's of Sulfonamide and Antibiotic Therapy, Philadelphia, W. B. Saunders, 1948, p. 152.

*Literature on request*

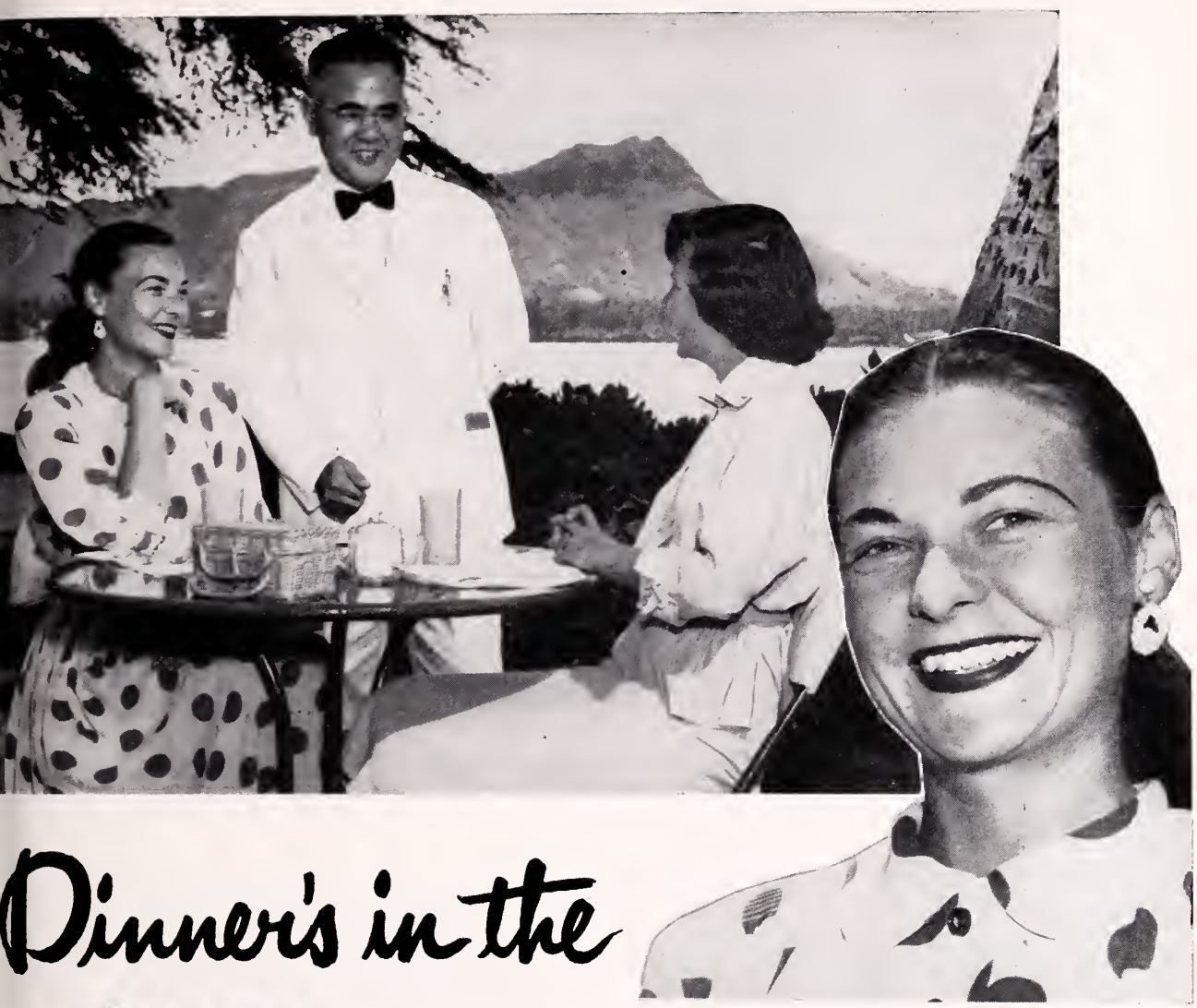



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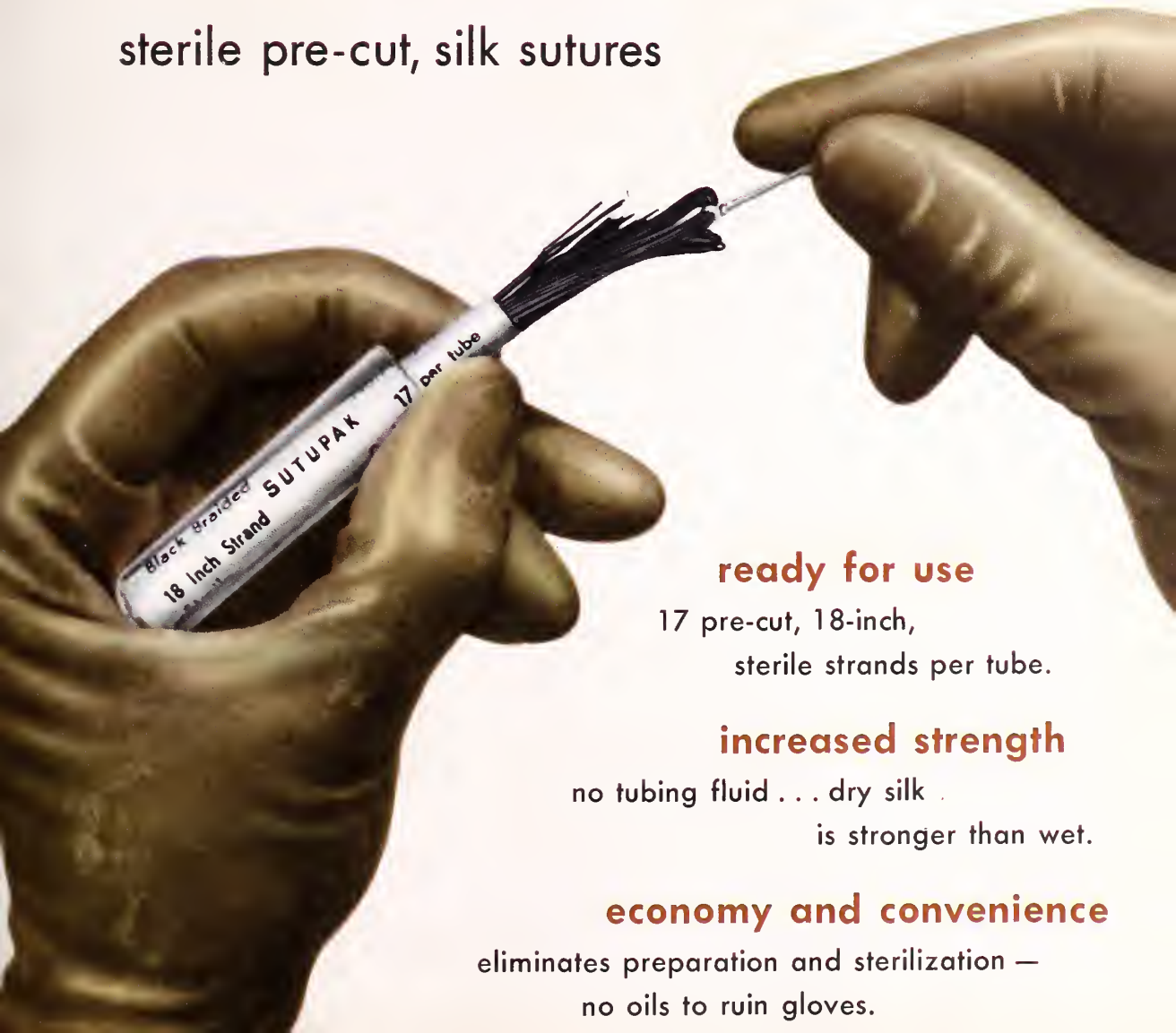
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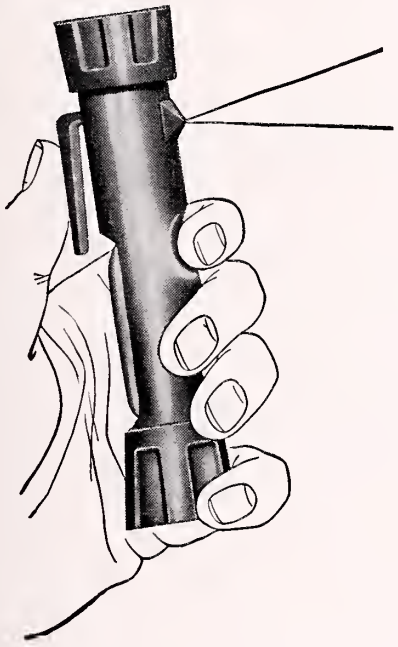
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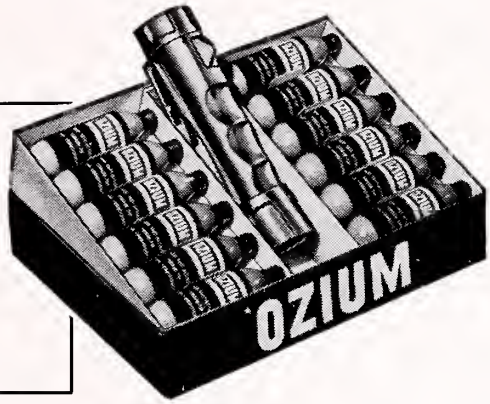
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## *wide-range antibiotic*

'Ilotycin' is a powerful antibacterial of proved effectiveness* in the treatment of infections due to:

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| 2. Hemolytic streptococci | Cellulitis, erysipelas, peritonsillar abscess, pharyngitis, pneumonia, scarlet fever, septic sore throat, tonsillitis, wound infections |
| 3. Pneumococci | Empyema, lobar pneumonia |
| 4. Corynebacterium diphtheriae | Diphtheria carriers |
| 5. Nonhemolytic streptococci | Some cases of endocarditis, genito-urinary tract infections |

*References

1. Heilman, F. R., Herrell, W. E., Wellman, W. E., and Geraci, J. E.: Some Laboratory and Clinical Observations on a New Antibiotic, Erythromycin ('Ilotycin'), Proc. Staff Meet., Mayo Clin., 27:285 (July 16), 1952. 2. Haight, T. H., and Finland, M.: Laboratory and Clinical Studies on Erythromycin, New England J. Med., 247:227 (August 14), 1952. 3. Smith, J. W., Dyke, R. W., and Griffith, R. S.: Erythromycin: Studies on Absorption Following Oral Administration and on Treatment of 33 Patients, to be published. 4. Spink, W. W.: Personal communications. 5. Romansky, M. J.: Personal communications.

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***DOSAGE:*** Adults—Total daily doses of 400 to 2,000 mg. are recommended, depending on the type and severity of the infection. Lobar pneumonia, bronchopneumonia, and some of the milder types of respiratory infections caused by organisms susceptible to 'Ilotycin' have consistently responded to doses of 100 mg. every four to six hours. For other infections, larger doses of 300 to 500 mg. every six to eight hours should be employed.

Children—6 to 8 mg. per Kg. of body weight every six hours. Therapy should be continued for at least forty-eight hours after the temperature has returned to normal and acute symptoms have subsided.

Available in 100-mg. specially coated tablets in bottles of 36.

# Public Health and Medical Care in Hawaii

E. RICHARD WEINERMAN, M.D., M.P.H.
BERKELEY, CALIFORNIA

DURING a two-month period in December 1951 and January 1952, the writer was privileged to conduct a survey of health resources and medical care programs throughout the Territory of Hawaii, at the request of the Regional Office of the International Longshoremen's and Warehousemen's Union (ILWU). This report summarizes the information compiled in a proud and progressive part of our country, whose health and medical record, should be better known on the Mainland.



DR. WEINERMAN

## Public Health

### *Patterns of Health and Disease*

The health status of the Islands' population is relatively good, and the pattern of disease is not greatly different from that in California. The health authorities are justly proud of the decreasing mortality rates, the dramatic victories in tuberculosis control, and the lack of epidemics involving the various vector-borne semi-tropical diseases. As on the Mainland, the primary causes of morbidity are the common respiratory and digestive disorders; the major causes of disability are the so-called metabolic or reactive diseases of middle and later life, and the sequelae of accidents; the chief killers are, there as here, the cardio-vascular-renal and neoplastic conditions. The 1950 Report of the Territorial Board of Health[1] provides an impressive chronicle of the health status of the population.

Table 1 presents selected public health indices among the various population groups. Particularly to be noted is the exceptional infant mortality rate. The high rates for Hawaiians and Koreans must be considered, at least partly, a statistical effect of the very small numbers involved—although health problems among native Hawaiians are relatively serious.

### *Public Health Services*

Public health services are developed to a relatively high degree in the Territory. A comprehensive Territorial Health Department has trained and experienced leadership, a large and

Received for publication September 8, 1952.

This article was prepared as a summary of factual observations concerning health resources in the Territory, and was not intended to include detailed evaluation of problems—which was one purpose of the formal survey report previously compiled. It was my original hope, in preparing this article, that the story of progress in health services achieved in Hawaii could become more familiar to the medical profession in the rest of the country. I do not wish to give the impression that this article represents a summary of the survey report itself. It does summarize the objective observations, not the critical reactions which pertain to administrative detail or local plantation problems.—E.R.W.

[1] Board of Health, Territory of Hawaii, *Report of Public Health for 1950*, Honolulu, 1951.

**THE WEINERMAN REPORT**

The Weinerman Report is a 182-page document consisting of two parts: a survey—generally laudatory—of the present situation with reference to medical care in Hawaii; and a set of recommendations—generally critical—for altering this situation. The proposed program would apply at first only to ILWU members, but is aimed at eventual comprehensive coverage for the whole population.

Every physician should read this report and consider carefully its implications with reference to the practice of medicine in Hawaii. A copy of it is available in the offices of the Medical Association.

Published herewith, for the record and as a matter of general interest and information, is a summary of the factual portion of the report, submitted by Dr. Weinerman for publication in the HAWAII MEDICAL JOURNAL.

We are pleased to be able to present, following the summary of the report, a series of comments on it, by R. J. McArthur, M.D., President of the Hawaii Territorial Medical Association; William M. Walsh, M.D., President of the Honolulu County Medical Society; Nils P. Larsen, M.D., Medical Advisor to H.S.P.A.; Charles L. Wilbar, Jr., M.D., President of the Department of Health; and William H. Wilkinson, M.D., President of the Territorial Association of Plantation Physicians.

Publication of this report does not constitute approval of it by the JOURNAL or by the members of the Hawaii Territorial Medical Association. The statements of opinion by Dr. Weinerman and the discussants are their own.

TABLE 1. *Selected Public Health Statistics by National Antecedents, Territory of Hawaii, as Compared with the Continental United States, 1950*

| GROUP | BIRTHS | | DEATHS | | INFANT DEATHS | | MATERNAL DEATHS | | STILLBIRTHS | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *No.* | *Rate (b)* | *No.* | *Rate (c)* | *No.* | *Rate (d)* | *No.* | *Rate (e)* | *No.* | *Rate (f)* |
| Territory of Hawaii | 14,059 | 30.1 | 2,892 | 6.2 | 335 | 23.8 | 12 | 0.9 | 175 | 12.4 |
| Hawaiian (a) | 166 | 12.8 | 244 | 18.8(a) | 10 | 60.2(a) | 2 | 12.0(a) | 5 | 30.1(a) |
| Part-Hawaiian | 3,595 | 46.6 | 307 | 4.0 | 95 | 26.4 | 1 | 0.3 | 64 | 17.8 |
| Puerto Rican (a) | 298 | 28.8 | 62 | 6.0 | 7 | 23.5 | .... | 0 | 5 | 16.8 |
| Caucasian | 2,703 | 33.0 | 629 | 7.7 | 88 | 32.6 | 3 | 1.1 | 39 | 14.4 |
| Chinese | 840 | 27.5 | 260 | 8.5 | 23 | 27.4 | 1 | 1.2 | 6 | 7.1 |
| Japanese | 4,568 | 24.7 | 979 | 5.3 | 69 | 15.1 | 3 | 0.7 | 33 | 7.2 |
| Korean (a) | 192 | 26.4 | 87 | 12.0(a) | 5 | 26.0 | .... | 0 | 1 | 5.2 |
| Filipino | 1,567 | 25.7 | 303 | 5.0 | 36 | 23.0 | 2 | 1.3 | 20 | 12.8 |
| All Others | 130 | 73.5 | 12 | 6.8 | 2 | 15.4 | .... | 0 | 2 | 15.4 |
| Continental U.S. | | 24.5 | | 9.6 | | 28.7 | | 0.7 | | 20.2(g) |

(a) Relatively high rates reflect the small numbers of births and deaths involved.
(b) Birth rate—number of live births per 1000 population.
(c) Death rate—number of deaths per 1000 population.
(d) Infant death rate—number of infant deaths per 1000 live births.
(e) Maternal death rate—number of maternal deaths per 1000 live births.
(f) Stillbirth rate—number of stillbirths per 1000 live births.
(g) Data for 1948.

(Source: Territorial Board of Health)

well-organized staff, and conducts a program of service and education which reflects the most modern concepts of public health. In addition to the traditional public health activities of registration of vital statistics, communicable disease control, sanitation, maternal and child health, etc., the Department has undertaken significant newer activities in control of chronic disease, hospital subsidization, mental health, dental health, and medical care of needy persons. The wide scope of health department responsibilities is reflected in the expenditure figures presented in Table 2.

TABLE 2. *Public Health Expenditures, T.H., 1948*

| COUNTY | TOTAL HEALTH DEPT. | PER CAPITA | TOTAL ALL PUBLIC HEALTH FUNDS | PER CAPITA |
|---|---|---|---|---|
| Total | $1,517,659 | $3.30 | $2,072,602 | $4.50 |
| Honolulu | 808,644 | 2.26 | 1,249,934 | 3.50 |
| Hawaii | 320,201 | 4.31 | 365,753 | 4.72 |
| Maui | 228,714 | 4.05 | 265,005 | 4.69 |
| Kauai | 160,100 | 4.47 | 191,910 | 5.35 |

(Source: Territorial Board of Health)

Local health departments function in each county, financed by territorial and federal subsidy. Full-time health officers are employed in two of the three rural counties, and carry on basic health protection activities chiefly through the work of public health nurses and sanitarians. An anomalous situation exists in the City and County of Honolulu, where the full-time Health Department is concerned with various medical care activities of an emergency and welfare nature, while local public health services are provided directly by the Territorial Board of Health.

Local health programs emphasize community health education, clinics for infants and expectant mothers, sanitation inspection, and control of communicable disease. Programs in nutrition, industrial hygiene, school health, mental hygiene and the like show definite weaknesses—although even these are better developed than in many rural counties on the mainland.

One exceedingly interesting program—reminiscent of the historical development of similar services in Sweden[2]—is the system of "government physicians". These are private and plantation practitioners who are designated by the Territorial Board of Health as public health representatives in the various local communities. In return for nominal monthly stipends, these physicians are responsible for certain vital statistics registration, conduct of public health clinics, and follow-up of epidemic cases. In addition, they determine eligibility and provide home and office medical care to needy persons in the rural communities. This system serves to bring the private doctor and the public health officer into relatively close and cooperative relationship.

Finally, the Territorial Board of Health conducts certain regular specialty clinics in the rural districts, for care of crippled children, Hansen's disease, venereal disease, tuberculosis, and mental disease. Most modern and well organized are the extensive case-finding and treatment programs for the control of tuberculosis and leprosy. Mass x-ray testing, frequent diagnostic chest clinics, sanatorium facilities on each island and continuous health education have produced especially marked reduction in tuberculosis death rates.

### *Voluntary Health Agencies*

As in other parts of the country, a vast array of uncoordinated and fragmentary services is provided in specific health fields by various private community agencies. Uneven financing and lack of integrated community planning result in some unnecessary activities, while needed services remain unavailable. Nevertheless, the 30-odd

[2] Weinerman, E. R. *Social Medicine in Western Europe,* School of Public Health, University of California, Berkeley, 1951.

TABLE 3. *Supply of Medical Personnel, Islands of Hawaii, June 1951*
(Includes only those in active clinical practice)

| | PHYSICIANS | | DENTISTS | | REGISTERED NURSES | |
|---|---|---|---|---|---|---|
| | *No.* | *Pop. per physician* | *No.* | *Pop. per dentist* | *No.* | *Pop. per nurse* |
| Territory of Hawaii | 416 | 1104 | 279 | 1647 | 947(1) | 483 |
| Oahu | 335 | 941 | 225 | 1401 | 747 | 421 |
| Hawaii | 41 | 1617 | 29 | 2287 | 101 | 662 |
| Maui County | 27 | 1756 | 14 | 3386 | 69 | 687 |
| Kauai | 13 | 2316 | 11 | 2737 | 30 | 1000 |

(1) Excludes 98 public health nurses, 20 school nurses and an estimated 101 active clinical nurses licensed after June 30, 1951. The number of registered clinical nurses currently inactive is not known.

(Source: Territorial Board of Health)

voluntary health agencies in the Territory spend over $3,000,000 per year in a sincere effort to supplement public health services, to pioneer in new areas and to educate the public and the legislature to a greater understanding of health needs.[3] Chapters of the leading national agencies function on the islands—e.g., American Red Cross, Tuberculosis Association, American Heart Association, American Cancer Society [the Hawaii Cancer Society has not affiliated itself with the national organization—Ed.], National Foundation for Infantile Paralysis, National Society for Crippled Children and Adults, Shriners' crippled children's facilities, etc. Local agencies, such as the Strong-Carter dental clinics, have also been organized. On the main island, the Oahu Health Council makes an earnest effort to coordinate the various voluntary activities.

## Medical Care

### *Medical and Hospital Resources*

In general, the development of medical resources in Hawaii is on a level comparable to (or better than) that in the rural States. The Honolulu center includes hospitals, specialty and technical personnel, laboratory and library facilities which are as adequate as those in any other major city without the advantages of a University medical school. In the rural areas, the supply and distribution of medical and auxiliary personnel, of small hospital facilities, and of welfare medical services—while falling short of standard requirements—is more nearly adequate than in many mainland farm districts.

Table 3 presents personnel data for the islands of the Territory. Figures for physicians in active practice and for general hospitals are presented above.

### *Physicians*

The supply of physicians is quite similar to the national pattern, with a definite concentration in the Honolulu area. The supply of physicians *in active practice* in the Territory may be evaluated in comparison with the following (rounded) physician-population ratios:

| | |
|---|---|
| Territory of Hawaii | 1:1100 |
| Continental United States | 1:980[4] |
| States 50% rural | 1:1050 |
| Honolulu | 1:720 |
| Cities of comparable size without medical schools | 1:800[5] |
| Rural Islands (average) | 1:1850 |
| U.S. counties with largest town less than 5000 population in States over 70% rural | 1:1800[6] |

The distribution of specialists is given in Table 4. Of the total 169 physicians claiming specialty status, 143 practice in Honolulu and 11 in the second city of Hilo. For the most part, the plantation area physicians are general practitioners, a few of whom are certified in general surgery.

TABLE 4. *Types of Specialists, T.H., January 1952*

| SPECIALTY | CERTIFIED BY AMERICAN BOARDS | TOTAL WITH PRACTICE LIMITED TO SPECIALTY |
|---|---|---|
| Allergy | .... | 2 |
| Anaesthesia | 1 | 1 |
| Dermatology | 4 | 5 |
| Ear-Nose and Throat | 8 | 8 |
| Eye | 10 | 10 |
| Internal Medicine | 12 | 21 |
| Obstetrics and Gynecology | 5 | 22 |
| Orthopedics | 2 | 6 |
| Pathology | 3 | 5 |
| Pediatrics | 10 | 17 |
| Proctology | 1 | 1 |
| Psychiatry and Neurology | 4 | 12 |
| Radiology | 5 | 5 |
| Surgery | 10 | 46 |
| Thoracic Surgery | 3 | 3 |
| Urology | 1 | 5 |
| TOTAL | 79 | 169 |

In Honolulu, there is an interesting development of private *group medical practice*. Six or seven such groups are in operation, two being relatively large (25 and 19 physicians) and housed in their own impressive clinic facilities. In addition, one plantation hospital at Puunene, Maui is staffed by a full-time seven-man group of physicians and surgeons who represent an excellent example of rural group practice.

[3] Hiscock, Ira V. *Public Health in Hawaii, 1950,* Oahu Health Council. Reprinted from the HAWAII MEDICAL JOURNAL, Vol. 10, No. 2, Nov.-Dec. 1950.

[4] Dickinson, F. G., Bradley, C. E. and Cargill, F. V. *Comparisons of State Physician-Population Ratios for 1938 and 1949,* Bulletin 78, Bureau of Medical Economic Research, American Medical Association, 1950.

[5] Mott, F. D. and Roemer, M. I. *Rural Health and Medical Care,* McGraw-Hill, New York, 1948, pp. 158-196.

[6] Mountin, J. W., Pennell, E. H. and Berger, A. G. *Health Service Areas: Estimates of Future Physician Requirements,* Public Health Bulletin No. 305, Public Health Service, 1949.

*Specialty services* constitute a real problem in the outlying rural islands, although private Honolulu specialists travel frequently to the smaller hospitals via the excellent inter-island airline systems, and the Territorial Board of Health sponsors certain specialty clinics conducted by visiting Honolulu consultants. A recent tendency is apparent for specially qualified physicians to settle in the smaller islands where adequate consolidated hospital facilities exist in the central community (i.e. Hilo on the Island of Hawaii, Wailuku on Maui, and Lihue on Kauai).

*Qualifications of medical personnel* are quite similar to those of comparable practitioners on the mainland—which means that there is far more modern and efficient practice than is usually recognized. Almost all of the island physicians were trained in mainland medical schools and hospitals, and many—particularly the plantation physicians—return periodically to mainland teaching centers for refresher work. Obviously, the opportunities for educational programs, conferences, consultations, etc. are not as easy as in the various States, especially for rural island practitioners. However, the hospitals and medical societies of Honolulu maintain an active conference schedule and play host periodically to national meetings, as was the case recently with a large surgical convention. While the rural practitioners face restricted educational outlets, the activity of local medical societies, the pattern of frequent trips to Honolulu, the efforts to keep up with the medical literature, and recent tendencies toward settlement of qualified consultants in the smaller centers all contribute toward a widening scope of educational contacts for the country doctor.

### *Hospitals*

The hospital picture is an exceedingly complex one. The *number* of general beds is adequate, although they are poorly distributed and too often found in obsolete and inefficient facilities. In contrast to an excellent network of tuberculosis hospitals, there are serious inadequacies in facilities for chronic and mental disease.[7]

Honolulu is fairly well supplied with general and special hospital facilities, which serve as a referral base for the entire Territory. There are 688 beds in its 3 general hospitals (two of which are approved for residency training), a 150-bed children's hospital, a 115-bed women's hospital, a 28-bed crippled children's facility, and a 771-bed tuberculosis hospital in the city. Nearby are institutions for Hansen's disease, mental disease, and chronic care. In addition, the giant Tripler Army Hospital serving all the Armed Forces has its vast facilities and personnel in the Honolulu area.

The rural areas present a picture quite unlike anything on the mainland. There the problem is that of too many beds, in an array of small, under-occupied, poorly equipped, inefficient and close-together hospitals. This is a reflection of previous days of isolated plantation communities, with larger populations than is now the case, when each company maintained its own medical facility. With current transportation improvements, diminution of rural populations, and modern trends in consolidated hospital construction, many of these rural facilities have become unnecessary and obsolete.[8] A definite tendency toward district consolidation has been taking place in recent years on the islands of Maui, Kauai and Hawaii, but regional coordination is still badly needed in the areas of rural Oahu, central Maui and the Hamakua Coast of Hawaii.

This unusual picture is summarized in Table 5. In interpreting the figures for occupancy rates, the fact should be kept in mind that small hospitals are expected to show lower average occupancy than large institutions. Nevertheless, the great majority of plantation-area hospitals have occupancy rates well below accepted standards even for facilities of small size.

A recent survey of hospital resources conducted under the Hill-Burton program[9] indicates that over half of all existing general hospital beds did not meet physical standards of approval, particularly as regards their being fire-proof. Only 58 per cent of the required number of *acceptable* general hospital beds, 50 per cent of needed mental hospital beds, and merely 25 per cent of the estimated need for chronic disease beds were available in 1950.

### *Welfare Medical Services*

The program of public medical services for the indigent and the so-called medically indigent is somewhat broader in Hawaii than in most of the States—but no less complex and disjointed.[10] Responsibility is divided between the Board of Health, the Department of Public Welfare, County Boards of Supervisors, "government physicians", public and private hospitals, and volun-

[7] Nebelung, R. G. and Schmitt, R. C. *Hawaii's Hospitals: Past, Present and Future,* Public Health Committee, Chamber of Commerce of Honolulu, T. H., 1948.

[8] Hospital Costs Study Committee. *Hospital Costs in Hawaii,* Public Health Committee, Chamber of Commerce of Honolulu, T. H., August 1949.

[9] Board of Health, Territory of Hawaii. *Revised Report of Hospital Survey and Planning,* Honolulu, June 1951 (processed).

[10] Public Health Committee, Chamber of Commerce of Honolulu. *Public Medical Care in Hawaii,* June, 1947.

TABLE 5. *Distribution of General Hospitals, T.H., January 1952*

| LOCATION | NUMBER OF HOSPITALS | TOTAL NO. OF BEDS | AVG. NO. OF BEDS PER HOSPITAL | AVERAGE PERCENTAGE OCCUPANCY | BEDS PER 1000 POP. |
|---|---|---|---|---|---|
| Island of Oahu | 12 | 1255 | 104 | 57% | 4.0 |
| Honolulu | 6 | 981 | 163 | 75 | |
| Rural Oahu | 6 | 274 | 46 | 39 | |
| Island of Hawaii | 7(a) | 435 | 62 | 42 | 6.7 |
| Hilo | 2 | 214 | 170 | 45(b) | |
| Rural Hawaii | 5 | 221 | 44 | 41 | |
| Island of Maui | 4 | 257(c) | 64 | 67 | 6.3 |
| Island of Molokai | 1 | 31 | 31 | 44 | 6.0 |
| Island of Lanai | 1 | 26 | 26 | 19 | 8.7 |
| Island of Kauai | 2 | 129 | 65 | 67 | 4.3 |
| All Islands | 27 | 2033 | 75 | 50% | 4.3 |

(a) Omits three small proprietary hospitals of 8, 6, and 5 beds.
(b) Occupancy rate for Hilo Memorial Hospital is 67%.
(c) Central Maui County Hospital now under construction will add 15-50 more beds.

tary social agencies and private industries. After many historical changes, during which primary responsibility varied between the county governments and the Territorial Department of Public Welfare, the Legislature recently passed a forward-looking measure [drafted by the Medical Advisory Committee to a subcommittee of the Holdover Committee—Ed.] which centralized all administrative authority for public medical care of both indigents and medical indigents in a new division of the Territorial Board of Health.[11] Troubles began, however, when the budget allotment proved to be only one-half of the estimated cost of meeting this responsibility. Then the Federal Security Agency advised that the usual matching funds for welfare services might not be forthcoming, since a single administrative agency was no longer responsible for the total welfare program.

At the present time, eligibility determinations for recipients of public welfare are made by local representatives of the Welfare Department. Medical indigents are designated by county social workers for hospital cases and by the "government physicians" (see above) for ambulatory cases.

Services are financed by local government with regular subsidy from the Territorial Board of Health. In Honolulu, needy persons are cared for in the private hospital out-patient departments, with private physicians donating their services. The hospitals are reimbursed by public funds for both out-patient services and for hospitalization of these cases. In the rural areas, ambulatory, home and hospital care is provided by those local doctors designated as "government physicians". Needy patients are hospitalized in county, non-profit or plantation hospitals—whichever happens to exist locally. No separate hospitals for indigents are maintained, and the county facilities are open to paying private patients as well as welfare cases.

[11] Public Law 129, Legislature of the Territory of Hawaii, 1951.

### *Voluntary Medical Care Programs*

With the exception of Blue Cross, the major types of existing voluntary prepayment plans are operating in the Territory. Most of the large mainland *commercial insurance carriers* are represented, the most important being the Prudential Insurance Company Plan now covering some 13,000 workers and families in the Pineapple Industry. The local *Blue Shield Plan*—organized by the Territorial Medical Society—is the Hawaii Medical Service Association, which covers some 50,000 persons and offers a Blue Cross type of hospitalization coverage as well as the typical medical-surgical benefits. Both the Prudential-Pineapple Plan and the HMSA provide at least partial coverage for home and office medical care. The lack of union-management welfare funds in the Territory (in contrast to the extensive development of such arrangements in the States) has meant that group contracts are made directly with employers or with voluntary associations of employees.

In the cities, the basic pattern of private fee practice supplemented by limited prepayment programs among industrial and white collar worker groups is reminiscent of the mainland urban scene. The history of sugar plantation medical services, however, has resulted in a pattern of rural medical care which is not to be found in the rest of the country, and which has made possible a wider distribution and a greater availability of medical care for rural people than is the case elsewhere. Counting the 50,000 persons covered by the Plantation Health Plan, an estimated 140,000 persons—or about one-third of the Territorial population—has some kind of prepaid coverage.

*Plantation Medical Care*

Before the union organization of sugar and pineapple workers in 1946 and 1947, a system of "perquisites" (housing, medical care, etc.) was provided by the plantation companies as an addition to the low daily wage rate. Medical services were rendered by salaried company physicians, working in plantation dispensaries and hospitals. All locally available physicians' care, nursing, drugs and hospitalization were provided free to the worker and his family. Many plantations maintained visiting nurse services and some paid for specialty consultations and referrals when requested by the company physician. The plantation medical staff was theoretically responsible for preventive services as well as curative care, and handled workmen's compensation and industrial hygiene in the fields and the mills. Private practice was limited to managerial personnel and the few local residents not employed by the sugar or pineapple companies.

*Pineapple Industry Plan.* With the abolition of the perquisites by union-management agreement in 1946, the Pineapple Industry discontinued its medical system (except for one small field camp on Maui and the company-owned hospital on Lanai) and instituted in its place a voluntary fee-for-service prepayment plan. The contract was carried by the Hawaii Medical Service Association until 1949, when rising premium charges led the industry to change to the Prudential Plan mentioned above. This insured fee plan stimulated the development of private practice in many of the rural communities which had previously been served only by salaried plantation physicians. Today, outside of Honolulu and Hilo where private practitioners predominate, there are about 40 plantation physicians* and about 45 private doctors in general practice.

*Sugar Plantation Health Plan.* In the Sugar Industry, the organized company medical program was continued, with a modest schedule of prepayment premiums from the workers replacing the free perquisite system. Each individual plantation continued to operate its own program. The monthly premium schedule of $1.65 per single worker, $2.50 per couple, and $1.10 per child up to a maximum of $6.00 per family, accounts for about half of the total cost of the program —the rest being financed by the companies. Medical services continue to be provided, to the 98 per cent of sugar workers who signed up for the new system, by company-employed physicians and their nursing and attendant staffs, with dispensary facilities provided also by the companies. On a decreasing number of plantations, the dispensary is part of a local company hospital. The current trend is toward consolidation of in-patient facilities in central county or non-profit hospitals.

Only services previously provided under the old perquisite system are now covered. Thus, specialist care, outside hospitalization, unusual laboratory and X-ray procedures, etc. are not included. As for general medical, drug and hospital service locally available, however, there are no limitations or restrictions.

The relatively high rate of pay, the assistance of nursing and technical staffs, the availability of equipped medical centers, the provision of post-graduate education opportunities, and the advantages of company-provided housing, car, equipment, etc., have all served to make these plantation positions most attractive to island physicians. At the same time, the patients profit from readily available family care at unusually low cost, almost unlimited hospitalization and drug benefits, and the services of nurses and attendants provided by the companies.

The problems and shortcomings of the system are significant, however. Many dispensary and hospital facilities are dilapidated and inadequate for modern professional work. Under-staffing in many areas is reflected in heavy patient loads (in some cases as high as 80 patients per physician per day), sometimes superficial service, and a frequent neglect of the personal amenities in patient care. A traditionally high level of utilization of medical care among plantation families has presented a heavy patient load, but has led to early care in illness and to emphasis upon preventive health services.

Workers complain particularly about the lack of specialist services and the employer-bias of some of the company physicians. An underlying difficulty is the financial pressure on many of the programs by plantation managers interested in minimizing company expenditures.

All in all, the quality and certainly the quantity of care received by the sugar workers is superior to that available to most other rural residents in the Territory—and in the rural mainland. The advantages of the plantation health center *method* would seem to outweigh the remediable defects of present *policy and administration.* A testimony to the success of these easily available medical services and relatively competent medical personnel is to be found in the recent summary report of sugar plantation utilization rates and health sta-

* Plantation physicians also maintain private practice in their communities.

tistics compiled by the Medical Advisor to the Hawaiian Sugar Planters' Association.[12]

### Summary and Conclusions

*The Territory of Hawaii* presents the picture of a modern industrialized, largely urbanized portion of our country—completely deserving, in the opinion of the author, of full Statehood. Her small island population is supported essentially by the sugar, pineapple, shipping and tourist industries and is composed of an increasingly integrated combination of the world's peoples. An efficient and closely coordinated group of large-scale industries and a strongly unionized labor force reflect the passing of the previous feudal system. Management, labor and government seem sincerely interested in the development of sound and comprehensive health services for the population.

*The health status* of the population is relatively good, reflecting a pattern of morbidity and mortality similar to that on the mainland. Major epidemic problems do not exist, although "modern" diseases have taken a heavy toll among the native Hawaiian population.

*The public health and public welfare services* of the Territory, despite personnel shortages and inadequacies of budget, are providing basic services of a wider scope than is generally true in comparable mainland areas. The pattern of voluntary social agencies reflects the situation in any of the States.

*The medical and hospital resources of the Islands*, while exhibiting significant inadequacies, are far closer in level of development to States such as Oregon or Missouri than to other Pacific Island areas. The major city of Honolulu enjoys a fairly complete array of medical, technical and hospital facilities, although the rural island areas are short of specialist personnel and are burdened with small, obsolete and inefficient plantation hospitals. The plantation medical system has produced a more even distribution of practitioners and general hospital facilities than is generally true in rural communities.

*Organized prepayment medical care plans* operating in the Territory present the same patterns of commercial insurance and non-profit service organization as are seen elsewhere. The unique program on the sugar plantations, a continuation of an older pattern of company-provided medical care under the perquisite system, is still based upon the method of salaried physicians in company-owned dispensaries and hospitals, providing direct services to plantation families. The modest schedule of voluntary premiums paid by the sugar workers constitutes about half the cost of the total program. The weaknesses in company management of the health system and the limitations on specialist and related services are balanced by the scope and efficiency of this type of health center organization.

*In general*, the fine health record of the Territory and the achievements of its modern public health and medical care programs deserve the recognition and the commendation of the rest of the country.

[12] Larsen, N. P. *Annual Report of the Medical Advisor*, Hawaiian Sugar Planters Association, Honolulu, T. H., 1951.

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### Comments

DR. R. J. MCARTHUR: Due to the widespread interest in and discussion of the Weinerman Report I wish to state that the opinions expressed in this article are my own and do not necessarily reflect the viewpoint of the Hawaii Territorial Medical Association.

Dr. Weinerman expressed many kindly remarks about medicine in Hawaii. The various managements of the plantations who have been responsible for the medical set up are undoubtedly grateful for this praise. The recommendations for better hospital facilities and more availability of specialists' care in some areas are well within the scope of the present organization. In fact, when considering the steady improvement of medical care on the plantations, these recommendations could be put into effect in the not too distant future by the medical inertia already traveling at a respectable velocity.

In the specific recommendations to the labor unions, there appears to be very slight if any digression from his general suggestions in the type of medicine advocated. Undoubtedly influenced by economy, there is no place for free choice of physician. Labor is to have a large measure of control over the medical facilities and the medical men.

It appears that it is not medical care that the Weinerman Report has introduced as an issue but who is to arrange for facilities, who is to select the medical personnel and who is to dictate the rules. The Weinerman Report is now ushering in the subject of medical care for labor-management bargaining. Will the control of industrial medicine be in the hands of management, in the hands of labor, or in the hands of both?

We doctors appear to be in the middle. Many of us may feel that management has done too good a job to relinquish its system. Many of us may feel that the patients involved are largely labor and that labor should direct traffic. It will do us no good to criticize either management or

labor. It is hoped that medical men will find means to guide both management and labor in a solution that will benefit medically everyone in our Territory. A committee of the Hawaii Territorial Medical Association is now studying industrial problems. Willingness to cooperate may prove the stepping stone to leadership.

DR. WILLIAM WALSH: An ancient Arabian proverb runs thus, in part: "He that knows not, and knows not that he knows not, is a fool. Shun him. He that knows not, and knows that he knows not, is simple. Teach him." The fool's ignorance is willful. The simple soul's darkness is helpless. Concerning the "Weinerman Survey" my ignorance is not willful but in my capacity to understand it let us just say I am helpless.

E. Richard Weinerman, M.D., M.P.H., of Berkeley, Calif.—described in *Nation* for Sept. 20 as a brilliant young physician and medical economist—was hired by the ILWU Regional Office in Honolulu to investigate existing medical services and facilities in Hawaii with emphasis on the current medical care and medical care plans affecting ILWU members and their families.

Dr. Weinerman has written that he does not wish the reader of the above report to obtain the false impression that *this* article represents a summary of the survey report itself. My comments will cover both the original and the summary above.

According to Dr. Weinerman, he was asked to make this survey "presumably because of his recent experience as Associate Professor of Medical Economics at the University of California and as Medical Director of the Permanente Health Plan in the West Coast," which posts he no longer holds.

The purpose of the study he summarizes as follows:

1) To survey the medical resources now serving ILWU members—a job which was apparently well done.

2) To evaluate the medical care plans presently covering ILWU members—also fairly well done.

3) To investigate other existing health services, public and private, which might be available to ILWU members. (Also done semi-objectively).

4) To propose ways and means of strengthening the overall program of medical services for union members.

Following a study of the entire report—to me these four items of purpose appeared to have been well covered but with additions, contradictions and a straying far afield. For example, criticism is directed at our inter-racial relationship and intolerances (nothing about our tolerances and understandings)—both in labor and our own medical profession. To me this is unnecessary, unjustifiable and entirely without foundation. A published list of names of the officers and committees of the Honolulu County Medical Society would enlighten the uninformed or uneducated as to our cooperative inter-racial way of living in Hawaii.

During an ILWU radio broadcast it was stated that the *real* objective of the Weinerman report is to maintain the *Medical Center Idea* and to improve upon it and coincidentally give the patients, i.e., workers, a voice in administration of the center, thus having joint administration of the medical plan by an equal number of employers and union-appointed trustees.

Personally, I like running my office myself and furthermore I have no desire to have a voice in running anybody else's business, even a union's—it is their prerogative to run their own business without my interference and I should like the same consideration. Where does the corner grocery store, meat market, clothing store, automobile agency and bar fit in to a program of this nature? Along this same line Dr. Weinerman states that in fairness to workers they should have some say about how their money is spent—who could disagree with this—certainly I cannot. But *I do disagree* with the premise that everyone but myself should have a voice in how I conduct my business.

Regarding the plantation employees' health system, Dr. Weinerman's major reason for demanding a change was that "The professional relationship between the patient and the doctor is confused by the simultaneous relationship between the worker and management officials. It necessarily lessens the *confidence* of the patient even where a doctor tries to do a conscientious job." Dr. Weinerman believes this can be corrected to the benefit of the profession (whose, I wonder?) and the patient by simple "joint administration (i.e., union and management—no doctors) of a fixed medical fund . . ." which contracts with doctors, hospitals, etc. for medical care. Let me ask who among us would not like some voice in the dispensing of his services?

Where in the listed purposes can you find a place for the following?

> The weaknesses of a union plan, as contrasted with a comprehensive public program, are significant.
>
> Unions engaged in medical care planning must, however, recognize that *long range* health security lies in sound community-wide programs, rather than in the limited and temporary benefits of single union plans.
>
> The design of any union plan should be such

as will fit into any later development of broader public programs, and the efforts of the union should not be distracted from the long range goal of comprehensive health service for the full population.

There are other items that could cover page after page—hidden barbs, innuendos and confusing statements couched in a disarming mode of presentation.

In *Medical Economics,* Dec., 1951, page 187, there is an article in which Dr. E. R. Weinerman describes four historical stages of "a clear chronological pattern in the development of health insurance":

Stage 1: Small, local voluntary "sick clubs" or "friendly societies," designed to "ease the economic burdens of private, fee-for-service medical care."

Stage 2: "Government subsidization and regulation of voluntary plans to stimulate wider coverage and broader benefits."

Stage 3: "The development of national health insurance schemes, at first including the voluntary plans as providers of service."

Stage 4: "Complete Governmental administration of health insurance, with trends toward tax-supported public programs rather than contributory social insurance methods. These later developments cover whole populations with more comprehensive benefits."

Is Stage 3 now being advocated and demanded?

When one enters the medical profession he has already decided to render service to humanity by attempting to relieve suffering—physical and mental. He has obligated himself to do so irrespective of financial gain. He is supposed to be "an upright man instructed in the art of healing . . ." and "the profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole condition of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, and without stint or scruple, to men of every country, and party and rank and religion and to men of no religion at all."*

Now to go back to my helplessness, it is not in understanding words per se, but in comprehending the ideologies, political theories, philosophies and moral outlooks on life. *I am not against any plan which will give better health care to more people,* but I am against all plans that stifle individual initiative, ambition, competition and self respect, whether it be among the illiterate or well educated; poor or wealthy.

The future of medicine, as a free enterprise, may seem dismal. The future of our country may be threatened by loathsome ideologies and odious political philosophies—but let us not forget our most dangerous foe to fight is still *apathy*—and let us hope that honest disagreement does not denounce one as a reactionary, social or political theorist, nor that it reprove one as being unprofessional for entering what has been termed (by one ILWU member) "the controversial socio-economic and political field . . ." After all, your health and life and my health and life and my own family's health and life are at stake!

DR. NILS P. LARSEN: This complimentary report on the health work in the Territory indicates not only a health conscious community, but a profession that can well be proud of its accomplishments. The constructive criticisms are good. These items were sent plantation doctors and they agreed they would work hard to correct all of them.

The comment, "All in all, the quality and certainly the quantity of care received by the sugar workers is superior to that available to most other rural residents in the Territory—and in the rural Mainland" would suggest acceptance of our system. The health records, the utilization rates as well as our surveys on worker attitude made on the plantations, indicate that a vast majority of the workers accept the present plan and are not clamoring for a complete change.

Every doctor must realize, if this had been the only report on Weinerman's survey, the editorial in the last Plantation Health bulletin would have been completely uncalled for. However, he wrote the ILWU "the efforts of the Union should not be detracted from the long-range goal of comprehensive health service for the full population . . . one of the primary objectives of both political and collective bargaining activity." Weinerman's real concept of where the Union's place in health work is, was given in another report to the Labor Council in San Francisco, i.e. "The program shall be a Labor program, designed for the benefit of working people . . . the line of authority for the operation of the program shall rest in the hands of . . . representatives of Labor . . . a centralized health center program under the auspices of the Labor Council." To show he probably meant the same for Hawaii, he wrote, "One composite program (medical) should serve sugar, pineapple, longshore and miscellaneous workers on all the Islands, and should also be open to interested outside groups in the Territory." (Farewell, HMSA.)

And again, "A full medical group center to be organized in Honolulu, composed of general practitioners and a complete team of specialists in the various fields of medicine. This group center would provide general family medical care . . . and would also constitute the source of consulta-

* *Principles of Medical Ethics* of the American Medical Association.

tion service for rural Oahu and the 'outside' islands."

Weinerman's concept given to the San Francisco Labor Council of such a center was "The constituency of such a health center organization shall be the duly elected delegates to the Labor Council . . . the majority of the Board of Directors shall be representatives of the labor movement, and the President and Secretary, respectively, of the Board of Directors."

The concept suggested is foreign to what the medical profession throughout the country believes would insure the best medical care and the continuing of proper professional standards. Weinerman admitted that the present plantation system gave more service for less money than any other plan, so why his demand for drastic changes?

I can only conceive that the present report is an attempt to blind the local profession from seeing the real purpose, i.e. the development of a system that can only result in the loss of our independence and freedom. Perhaps Weinerman doesn't realize this himself for the principles quoted are not so clearly given in his presently enclosed recommendations. I refer you to his report to the San Francisco Labor Council for the full blueprint of his concept of medical care.

His recommendations to our Society on superficial reading seem innocuous but the hidden daggerpoints, I believe, are more dangerous in pushing us toward socialization than Oscar Ewing's less well veiled threats. Well polished sentences are often as enticing to humans as salmon eggs are to trout. Weinerman was furious with me because I complimented him on a good comprehensive study job and completely disagreed with his recommendations. Weinerman, I believe, is being used as a professional camouflage to change a well functioning medical care program to one giving more power and complete control of medical care to a group who has had no experience in such work. We do not believe that is fair, and we do not believe it will result in better medical care for the workers.

His recommendation, "independent status for participating physicians, with professional control of all professional policy" is a real "come on" that can have little meaning in face of, and if, "the majority of the Board of Directors shall be representatives of the labor movement. . . ." The sweet words as given in the accompanying report do not—to my mind—give the real Weinerman philosophy of medical care for the community. That, after careful study by the San Francisco doctors, was rejected by them 832 to 26. They feared its effect on the standards of medical care.

Dr. Frank Dickinson of the A.M.A. Bureau of economic research wrote to the President of the San Francisco Medical Society after studying the San Francisco Weinerman report—

> Accordingly Labor must picture medical plans as woefully inadequate in order to get more dollars out of the employer as additional (tax free) compensation. Labor has the power to compel compliance, so why not use that power! Use it even though using this great power may ultimately produce a society in which there will be no labor organizations. Voluntary pre-payment plans based on sound actuarial principles are very desirable. It is only when the voluntary aspects and sound financial aspects are lost, that they become undesirable. Misrepresentations of existing facts as found in this study, only confuse the issue and certainly are not constructive in a program for improved national health.

The Society in the past has been afraid of government regulation because of the danger of abuse. They believed that through the HMSA and other insurance and indigent care plans, comprehensive medical service can be had by all without the danger of abuse when the regulation falls into non-medical hands.

Let us improve what we have (and I think U.S. medicine is the best in the world) rather than adopt a completely new system that has all the earmarks of an attempt by an aggressive "left wing" group to get control of a large part of medical practice.

Dr. Charles L. Wilbar, Jr.: It should be pointed out at the beginning of my comments that they are concerned with this specific article of Dr. Weinerman's, although he has written several reports as the result of his two-month study in Hawaii, with some of the conclusions in the other reports being of a more controversial nature than in this one.

In this report, Dr. Weinerman gives credit where credit is due and presents correct statistics as obtained from the Bureau of Health Statistics of the Territorial Department of Health. He points out a number of good points in the health picture, both on the plantations and in the Territory as a whole. In the section on public health services, he flatters the Health Department's programs in chronic diseases and dental health; in my opinion, the preventive programs in Hawaii in these areas are definitely weaker than in most of the states.

It is significant that Dr. Weinerman points out that the system of government physician services tends to bring the private physician and the public health officer into relatively close and cooperative relationship. Any system of placing plantation physicians on full-time contract services might jeopardize the government physician set-up as, in

a number of areas in the Territory, the only person available for employment as a government physician is the plantation physician.

In regard to welfare medical services for the indigent and medically indigent I cannot agree with the statement that ". . . . the budget allotment proved to be only one-half of the estimated cost of meeting this responsibility." The question here depends upon just how much the Territorial government should provide in this area. The Legislature has seen fit up to now to rule that some of the responsibility remain with the counties and with the individuals themselves. Any change in this regard is up to the legislators after reviewing the initial experience of this program during the present biennium.

In dealing with the subject of medical care on the plantations, two statements seem to me to be most significant. These are included near the end of the report. One says "All in all, the quality and certainly the quantity of care received by the sugar workers is superior to that available to any other rural residents in the Territory and in the rural mainland." Another says "The weaknesses in company management of the health system and the limitations in special and related services are balanced by the scope and efficiency of health center organization." Some weaknesses in the plantation set-up are pointed out. Two of these have been pointed out by the Department of Health and by the Association of Plantation Physicians, namely, the need for consolidation of small rural hospitals and the need for more widely available consultation services. Steps are being taken in this direction, particularly on the islands of Kauai and Hawaii.

The recognizable fact remains in this area that the system which has prevailed on the plantation has brought about an unusually good health picture for this rural population. Consequently, considerable thought and care must be given to making any significant changes in a system which is already working well. No system of medical care is perfect and undoubtedly improvements can be made in the plantation system. These improvements are needed more in some areas than in others. Revolutionary change is not called for in this particular paper and it would seem to me it should not be called for, considering the results of the present system.

DR. W. H. WILKINSON: Many comments, both in praise and condemnation of Dr. E. Richard Weinerman's survey of Hawaii's rural medical health, have been made orally and in writing during the past several months. No attempt will be made here to analyze his report or recommendations. Suffice it to say that there is considerable variance in his report to the physicians of Hawaii and in that to the ILWU. The former contains sound medical recommendations which appear to have been made in an effort to improve the already existent medical plan—excellent as it is—for the exclusive benefit of the patient. The latter, however, appears to have been made with the idea in mind to promote the ILWU in a role as benefactor to the working man.

What was the need—what was the motivating force that prompted this medical survey in the first place? It could not have been that the people of rural Hawaii were suffering for lack of good medical care, for they presently enjoy the fruit of the world's best rural medical system—and there is ample unbiased statistical evidence as compiled by the Health Department to prove this. It could not have been that the monetary burden had become unbearable to the working man of rural Hawaii, for costs of medical and hospital care have risen less slowly than other commodities of our present day society and most of this increase has been paid for by the employer. It could not have been a burning desire within Dr. Weinerman to crusade for better care for the working man, else he would have turned his talents to other areas less remote from San Francisco than is Hawaii and perhaps even to rural areas where there is no system of medical care at all. Could it have been a political move on the part of the ILWU to pick the ripened fruit, slice it up, and offer it to the world for inspection with the same pride a new mother has in her first born, and then receive the praise and accolade justly due it for the inception, the nurturing and the perfection of a plan in which it had no part?

The physicians on the plantations in Hawaii are organized in a local association which is a component society of a national group, The Industrial Medical Association. Both groups are constantly and actively improving the medical care to the worker. The members of these organizations are not only physicians in every sense of the word, but are trained specialists in industrial medical problems. In Hawaii they have done a commendable job in providing medical care to the worker for a half a century. Is there any reason to change methods or control of this fine medical system? The Territorial Association of Plantation Physicians doesn't think so and at its recent annual meeting resolved to resist any change in the medical program which might act adversely on the excellent care provided the plantation worker.

# Human Fascioliasis in the Hawaiian Islands

JOSEPH E. ALICATA, Ph.D.
HONOLULU

ON DECEMBER 7, 1951, Dr. G. N. Stemmermann of the Hilo Memorial Hospital informed the writer of a recent death of a 51-year-old woman which had resulted from a massive infection of the liver with flukes. Two of these flukes (Fig. 1*c*) were examined and found to resemble those of Fasciola gigantica.



DR. ALICATA

The above case of human fascioliasis represents one of at least 18 other such cases which are known to have occurred in the Hawaiian Islands. As shown below, the fact that most of the flukes found have been discovered by chance during surgical operations or in other accidental ways indicates that many other cases have occurred but have remained unrecognized. Since this form of infection represents a problem of medical and public health importance, it is believed to be of considerable local interest to summarize the cases which have been known to occur in the Islands and to give an account of the prevalence of bovine fascioliasis, which undoubtedly represents the main source of human infection. It is believed that this information is useful in creating awareness of this parasitic infection so that it may be helpful in better diagnosis of the disease and in taking suitable preventive measures.

## Human Fascioliasis and Cases Known in Hawaii

The infection of man with flukes of the genus Fasciola is usually regarded as accidental. The normal hosts for these parasites are cattle, sheep, and other herbivorous animals. In the normal hosts, the adult parasites are ordinarily found in the biliary ducts of the liver and are therefore referred to as liver flukes. In abnormal hosts, such as man, these flukes frequently wander also to the lungs, under the skin, and in other extrahepatic locations;[1] furthermore, the parasites often fail to undergo proper sexual development and fail to produce eggs. As indicated below, these forms of abnormalities have been noted in local infections and present a problem in the recognition of the disease. In extrahepatic infections and in cases where the parasites are sterile, the clinician may have to depend on immunologic tests for diagnostic aid.[2]

The first record of human fascioliasis in Hawaii is a report of six cases by the late Dr. George Herbert[3] in 1906. Since the report appears in one of the early publications of the Hawaii Medical Society and is not readily accessible, it is believed desirable to present it in its original form. Following the report of Herbert, other cases which have been known locally are discussed chronologically.

### Dr. Herbert's Report of Cases

CASE 1.—The first case was Mrs. L. who for three years was supposed to be a "neurotic" with spinal Hyper-Aesthesia, loss of flesh, various pains about her body, especially a girdle pain about the waist, gastric disturbances and its concomitants; cardiac intercostal neuralgia. She was a patient of Dr. Ing's and afterwards of the late Dr. Brodie's and as he was away at the time, I treated her for various complaints and among others an irritable larynx and pharynx: for this I prescribed a spray containing some dilute sulphuric acid and tannic acid. One day, after using the spray, she coughed violently and brought up a "fluke," I was personally unacquainted with the gentleman and none of my friends could tell me what it was, I took it around to Dr. Brodie, who had just come to town, and he immediately recognized the "Distoma Hepaticum." The lady made a splendid convalescence and became strong and healthy, and has had none of the troubles since.

CASE 2.—Was a young lady Mrs. D. She had been confined four weeks previously, had enjoyed good health while enciente [enceinte] and had no symptoms of any kind. One day she drew my attention to three blue points on a slightly swollen circular patch on the right side of chest, low down about the eighth and ninth ribs in the axillary line, it resembled in appearance a carbuncle, but no pain nor sign of inflammation such as redness. I advised her to poultice it with flaxseed, two or three more blue points appeared, one day she telephoned to me to come in a hurry, something was coming out of her side, and out walked "fluke" No. 2.

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[1] Neghme, A., and Ossandon, M.: Ectopic and hepatic human fascioliasis, Am. J. Trop. Med. 23:545 (Sept.) 1943.

[2] Belding, D. L.: Textbook of Clinical Parasitology, Century and Crofts, New York, 1952, p. 1139.

[3] Herbert, George: Five Cases of Liver Fluke in Hawaii, Trans. 15th Ann. Meet. Terr. Med. Soc. 1906:92, 1907.

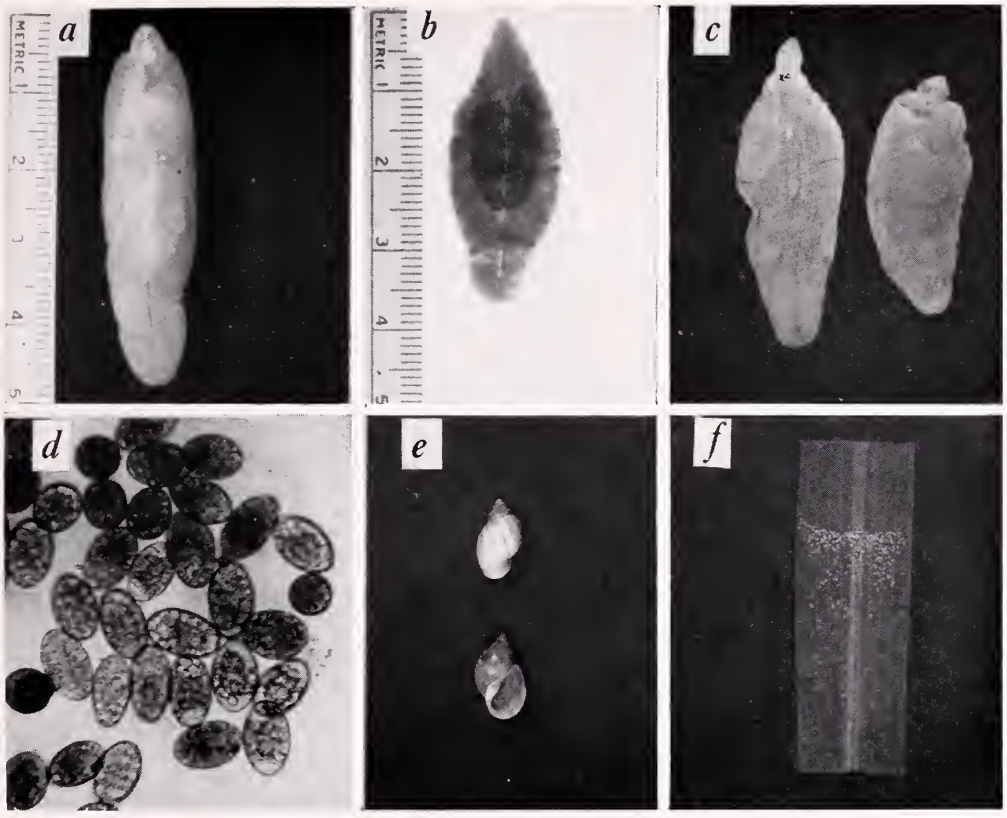



FIG. 1. (*a*) (*b*) and (*c*) Adult liver flukes recovered from the liver of man in Hawaii (see text); (*d*) Eggs of Fasciola gigantica; (*e*) Lymnaeid snails, Fossaria ollula, intermediate hosts of fasciolid flukes in Hawaii; (*f*) Infective cysts of Fasciola gigantica encysted on grass. (All photographs, except (*d*), natural size.)

CASE 3.—Proved much more complicated, and I regret, here I was unable to obtain the animal himself. A young man Mr. G. consulted me with pleurisy of the left side with effusion, I treated him with counter irritation, etc., and sent him off on a ranch on Lanai, for several months and he made a complete recovery. The year following, at the same time, he again consulted me with pleurisy of the right side and some effusion, I prescribed the same way, but he became worse, and this being during the cholera epidemic in Honolulu, he was unable to obtain a passage on a steamer to get back early and see me. When he did return, he walked into the office with complete dullness of right side, due to effusion, I immediately sat him down and with an aspirator removed over one gallon of bile, the fluid was thick with albumen, and boiling coagulated it solid. In two weeks he had filled up again, and again in two weeks. I then made an incision between two ribs and ran in a drain of sterilized lampwick, hoping to form a biliary fistula, this kept open a steady drain of bile for weeks, but the antiseptic bile prevented the inflammatory reaction I had looked for, and he could not stand the drain and finally I resected four ribs and endeavored to locate the perforation from the liver but failed to do so. I regret that I had to do this, "post-mortem," a few weeks later, when I found a typical piece of fluky liver with two bile ducts opening directly through the diaphragm into the right pleural cavity; these openings that were close together were about one eighth of an inch in diameter and one eighth of an inch apart and opened directly through the middle of the right side of the diaphragm.

CASE 4.—Was a lad, seven years old, living on the other side of the Island. His father telephoned to me that the boy was ailing and had been for some weeks previous (he had in fact not been well for two years off and on), he was then suffering much with occasional pains in abdomen, attacks of high temperature, losing flesh and getting pallid, he would cry much at night with pains, which were difficult to locate. As I was unable at the time to go over and see him, we met on the Pali, and the symptoms were decidedly suggestive of intestinal irritation caused by some parasite. I therefore requested some of the foeces to be sent over the following morning. Microscopical examination of this revealed the "ova" of the "Tricocephalus dispar" in immense quantities but no "ova" of the distoma. The treatment consisted of vermifuges of different kinds with no results as to worms, but improvement of general health. Two months later, a swelling appeared under the right breast, this was tender and slightly inflamed [*sic*], poultices were applied; the swell-

ing travelled towards the axilla which was swollen in turn and the other parts recovering completely. The swelling travelled backwards and forwards up and down the chest and to back of neck for two months during which time I was out of the country, till eventually the right side of the neck began to swell, but no fluctuation, (which point is characteristic of all these swellings), and there was so much engorgement and tumefaction of the neck that the head was turned to the opposite side. In a few days the ear became exceedingly painful with "otitis media." Hot douches and applications relieved this somewhat, and one morning when the father went to wash out the ear, he saw the "distoma hepaticum" No. 4 lying deep in the ear; he removed it with forceps, and the child made an uninterrupted recovery from all symptoms. Has not had any illness since, yet the "ova" of the "Tricocephalus" remained in the foeces long after, and possibly though this was seven years ago, are still contained in the foeces.

CASE 5.—Was a man aged 40, he was taken down with symptoms of grippe and followed by an intermittent fever, high temperature, and peculiar symptoms with pain in right of chest and upper abdomen, great gastric distress and dyspepsia, which for many months had been bothering him, off and on. His symptoms finally suggested an abscess on the liver, and accordingly we operated [*sic*] him. The examination revealed an abscess of the liver in the left lobe anteriorly just above and external to the gall bladder with the same macroscopical appearance as I had seen in the skin and superficial tissues in other cases of distoma, the incision was sewn up, with packing to the abscess which was curetted out forty-eight hours later. No "ova" or anything of note was revealed from the microscopical examination of the scrapings, the patient made an excellent recovery and steadily convalesced. During his convalescence, he developed a laryngitis and a swelling appeared on the throat which so interfered with the recurrent laryngeal nerve as to cause his loss of voice, at times. This was treated by galvanism, to stimulate the nerve, it probably stimulated the fluke, for one day the patient sneezed violently and the fluke was ejected. The patient's general health and physical condition since has been superb. The operation on this patient's liver took place in September, 1904, his throat and neck troubled him in March, 1905 and he recovered with the removal of the fluke 3 months later.

CASE 6.—Since writing the above, I wish to record the following peculiar case: Mrs. C., a Portuguese lady and mother of several children, came to my office. The history of her case was as follows: Two years ago, without any physical signs of pulmonary trouble, she had a severe hemorrhage haemoptysis, which reduced her greatly, and it took her several months to regain her strength, during which time, upon some old woman's advice she lived freely on water cress with her otherwise generous diet. In June, 1906, she had praecardial distress and frequent attacks of faintness and feeling of oppression in the left side of the chest around the heart and stomach. Urine, heart and lungs were found normal. Coming into my office last November, her abdomen was distended with five months of pregnancy, I found the veins over the lower ribs and cartilage below the nipple and in the left nipple line very prominent, and in the sheath of the left rectus abdominis 2 inches above umbilicus was a haematoma with an opening through the skin through which you could express the black currant jelly like, congealed blood. The appearance was typical of a fluke, and I warned her at once to look out for the exit of such a thing. The next day she had quite a severe hemorrhage and as I was unable to attend her at the time, she was taken to the General Hospital and cared for. After several days, to the surprise of the House Physician and Nurse, a live "distoma hepatica" was found on the dressing. She continued well. Her child was born at time with no trouble and she is enjoying fair health.

## Additional Cases

CASES 7 to 15.—In a report of a brief survey on fascioliasis in Hawaii, the late Dr. M. C. Hall[4] made a mention of 9 additional cases of fluke infection in man. He stated as follows: "*Fasciola hepatica.* The earliest case known to me of human fascioliasis in Hawaii is represented by a specimen in the U. S. National Museum Collection (No. 4131). This specimen was collected in Honolulu on May 12, 1905, by G. C. Potter, the worm being sneezed from the nose, and was sent in by Jacob Katinsky for identification. . . . In the course of a month's visit in the Islands, I learned of 8 additional cases of human fascioliasis. At Hilo, on the Island of Hawaii, Miss M. E. Campbell, a medical technician, showed me a specimen of *F. hepatica* 43 mm. long removed at operation from the gall bladder of a boy 10 years old; a physician stated that the boy had had a subsequent operation and that a second fluke had been found and removed. Dr. L. L. Sexton told me that he had found small flukes, the size of the nail of the little finger, in the body cavity at operation in 4 cases during the course of 25 years. . . . Finally, I learned of 3 human cases, diagnosed as such, on the Island of Oahu." A discussion on the actual identity of the above flukes is presented later in this paper.

CASE 16.—In 1938, Swanson,[5] in a note on parasites found in the Hawaiian Islands, records seeing a liver fluke specimen, Fasciola gigantica, recovered from the abdominal cavity of a girl during a surgical operation. Swanson also mentions that a physician in Honolulu had supplied him with information on two other cases, one being a fluke specimen coughed up with the sputum and the other a live fluke sneezed from the nasal passages. The writer is of the opinion that the last two cases are the same as recorded above by Herbert under cases 1 and 5.

CASE 17.—On December 10, 1945, Mrs. R. P., age 29, of Honolulu, was operated upon by Dr. C. M. Burgess for partial obstruction of the common bile duct. The obstruction turned out to be a liver fluke 38 mm. long and morphologically identical with F. gi-

[4] Hall, M. C.: Problems of Parasitism in Hawaii, Rev. de Parasitol. 2:367, 1936.

[5] Swanson, L. E.: A Note on the Parasite Fauna of the Hawaiian Islands, Proc. Helm. Soc. Wash. 6:29 (Jan.) 1939.

gantica (Fig. 1*b*). Although the parasite was apparently mature, there were no eggs in the uterine duct.

In connection with the above case, the writer learned, through conversation with the patient at her residence, that she had not been off the Island of Oahu and did not usually eat much water cress. During the conversation a large fish tank containing some snails and green water plants was noticed in the house. A discussion about this aquarium revealed that the son of the patient had from time to time placed in the tank various kinds of snails and green plants which he had collected from streams around Honolulu. Furthermore, it was learned that the patient had regularly changed the water in the tank by siphoning off the water with the aid of a wide rubber tubing. This she started by mouth-suction, and, in so doing, occasionally some of the water reached her mouth. The writer is of the opinion that this practice was one of the means by which this patient could have become infected. The fluke cysts in the tank could have derived from infected lymnaeid snails or infected vegetation placed in the tank.

CASE 18.—On March 30, 1946, Dr. L. L. Sexton of Hilo submitted to Dr. E. A. Fennel of Honolulu a fasciolid fluke which had been coughed up by an 18-year part-Hawaiian girl (Miss J. M.). The fluke, which was submitted to the writer for identification, was found to be 33 mm. long by 10 mm. wide, had an elongated appearance, and showed no eggs in the uterus. Because of the general morphological characters, it was tentatively identified as F. gigantica.

The above patient had been admitted to the Hilo Memorial Hospital on March 25, 1946, with a history of a bout of indisposition for about a month, nausea, vomiting, chills, and fever. The fluke was coughed up two days after hospitalization. According to recent information (July 8, 1952) received from Dr. G. N. Stemmermann of Hilo, a follow-up of this patient has revealed that she had transient episodes of epigastric pain, fever, and nausea until 1950. Subsequent to that time she has been well. X-ray of the epigastrium at the present time shows the presence of 1 cm. sized calcified areas on the region of the liver.

CASE 19.—This refers to the case already mentioned at the beginning of this report. On December 7, 1951, Dr. G. N. Stemmermann wrote to the writer as follows: "I have recently performed a necropsy on a 51-year-old Japanese woman, a resident of Wainaku, Island of Hawaii. She died as a result of a massive infestation with liver flukes. These caused suppurative cholangiitis, liver abcesses and diffuse hepatic necrosis."

Two of the above-mentioned flukes, which had been placed in formalin solution, were submitted to the writer for identification. After the specimens were straightened out, one measured 41 mm. long by 14 mm. wide and the other 32 mm. long by 13 mm. wide (Fig. 1*c*). After the specimens were passed through various grades of alcohol and finally cleared in xylene, they were found to have no eggs in the uterus. Because of their size and general morphological characters they were tentatively identified as F. gigantica.

## Identity of the Flukes in Local Animal and Human Infections, and Remarks on the Life Cycle of these Parasites

The genus Fasciola possesses well-known morphological characters and is represented by 2 species of flukes, namely, F. hepatica and F. gigantica. These two species are differentiated largely by their size and the shape and size of the eggs. F. hepatica is leaf-like and reaches a maximum length of about 30 mm. The eggs measure .130 to .150 mm. by .060 to .090 mm.[6] F. gigantica appears in most cases to be more elongated than the other species and reaches a maximum length of about 50 mm. The eggs (Fig. 1*d*) range from about .156 to .197 mm. by .090 to .104 mm.[7] In experimental infections, young mature specimens of F. gigantica have been found to have eggs in the uterus when measuring about 26 to 32 mm. long by 6 to 9 mm. wide.[8] By the use of these criteria, one may assume that the 4 flukes recorded in cases Nos. 17, 18 and 19 were sterile.

Fasciola gigantica and F. hepatica are known to be present in cattle in the Hawaiian Islands. The former, which is the more common, is found in animals on all the larger islands.[7] As to F. hepatica, only one specimen has thus far been definitely identified. This was collected by the writer in the liver of a cow raised near Kaneohe, Oahu.[9] Since this species of fluke had not been encountered in numerous previous observations carried out by the writer and his associates, the finding leads to the belief that the introduction of F. hepatica in Hawaii is very recent.

Lutz,[10] in 1892, was the first to report that the common liver fluke in cattle in Hawaii was Distoma hepaticum (=F. hepatica). However, it is believed that Lutz erred in his determination, as this has not been substantiated in recent studies, and because examination of fluke specimens collected in Hawaii in 1892 and 1894 and now in the U. S. National Museum Collection, has proved them to be F. gigantica.

In the account given above under cases Nos. 7 to 15, the fluke specimen recovered from the man in 1905 is listed by Hall as F. hepatica. However, a recent re-examination of this fluke by Mr. A. McIntosh of the U. S. Bureau of Animal Industry proved it to be F. gigantica. Moreover, another liver fluke specimen in the above cases, said to be 43 mm. long and recovered from a 10-year-old boy in Hilo, is also reported by Hall as F. hepatica. This specimen was recently re-

[6] Morgan, B. B., and Hawkins, P. A.: Veterinary Helminthology, Burgess, Minneapolis, 1951, p. 400.

[7] Alicata, J. E.: Observations on the Life History of *Fasciola gigantica*, the Common Liver Fluke of Cattle in Hawaii, and the Intermediate Host, *Fossaria ollula*, Hawaii Agr. Expt. Sta. Bul. 80:22, 1938.

[8] Alicata, J. E.: Life History of *Fasciola gigantica*, Hawaii Agr. Expt. Sta. Rpt. 1937:86, 1938.

[9] Alicata, J. E.: Autochthonous Infection of Cattle in Hawaii with *Fasciola hepatica* Linn., J. Parasitol. 38:495 (Oct.) 1952.

[10] Lutz, A.: Zur Lebensgeschichte des *Distoma hepaticum*, Zentbl. f. Bakt. u. Parasitol. 11:783, 1892.

studied by the writer and photographed (Fig. 1*a*). This fluke actually measured 48 mm. long and was found to be sexually mature. Five of the eggs which were dissected out of the uterus were found to be .178 to .193 mm. by .090 to .097 mm., measurements which agree with those of F. gigantica.

Of the flukes found in the 19 human cases in this paper, in 5 the flukes are known to be more than 30 mm. in length, and therefore within the measurements known for F. gigantica. Furthermore, in one of these specimens, the egg measurements also fall within the size known for this species. As to the flukes found in the other cases, there is no information available as to what species of Fasciola they represent. In many instances, the flukes were probably immature and therefore difficult to identify. However, since flukes found in man in Hawaii undoubtedly originate from bovine infections in which F. gigantica is the most common parasite involved, it appears safe to assume that all human fasciolid infections were caused by F. gigantica. If this is the case, there are more cases of this species of fluke reported in Hawaii than have been known anywhere else. Outside of Hawaii, only 3 cases have been reported—from Africa, French Indo-China, and Tashkend (Central Asia).[11] Most of the cases of human fascioliasis have been attributed to Fasciola hepatica; at least 130 of such cases have been reported from various sheep-raising areas of the world.[2]

The life cycle of fasciolid flukes requires two hosts. One is the primary mammalian host, where the parasite reaches maturity and lays eggs, and the other is a secondary or intermediate snail host, where the fluke undergoes larval growth and asexual reproduction. In mammalian infections, the adult fluke lays undeveloped eggs in the biliary ducts, and these then pass with the bile into the small intestine and are finally eliminated with the feces. Upon presence of water, the eggs develop in about fourteen days and hatch, giving rise to free living miracidia. These swim actively in water until a proper snail host is found. They then bore into the snail and undergo asexual reproduction in which a large number of cercariae are eventually produced from a single miracidium. Such a development requires about six weeks.[7] In Hawaii, the lymnaeid snail Fossaria ollula (Fig. 1*e*) is the only suitable intermediate host.[7] The fully developed cercariae emerge from the snail and, after swimming in water, encyst on any submerged vegetation (Fig. 1*f*), rocks, debris, or even on the surface of the water. Under presence of water currents, the swimming cercariae may be carried to a considerable distance before they encyst. Encysted cercariae (metacercariae) have been found to be viable after four months but not after eight months.[12] Infection with these flukes occurs in animals as a result of eating vegetation in or from swampy areas, which contain encysted cercariae, or drinking water from streams in which encysted cercariae are floating. In human beings, although contaminated water can be a source of danger, most infections most likely occur as a result of eating raw vegetation grown in water which has become contaminated.

[11] Craig, C. F., and Faust, E. C.: Clinical Parasitology, Lea and Febiger, Philadelphia, 1940, p. 772.

### Animal Fascioliasis in Hawaii as a Source of Human Infection

As already indicated, fascioliasis is primarily a disease of herbivorous animals. In Hawaii, bovine infection exists on all the larger islands, especially Oahu and Kauai. In these areas, the disease is more prevalent in the windward coastal regions. On Hawaii, infection has occurred principally among dairy cattle in the vicinity of Hilo. On Maui, infected animals have been found in a few scattered areas around Wailuku and Lahaina and in the coastal region from Waikamoi to Kipahulu.[13] Beef cattle from 3 of the Islands slaughtered in Honolulu during 1935 were found to show the following incidence of infection: Hawaii, 4.1 per cent; Molokai, 52.3 per cent; Oahu, 71.1 per cent.[14]

Although cattle are considered the major source of dissemination of liver flukes, reports from hunters and other sources[15] have shown that wild hogs are also infected. These animals are known to roam wild in the swamps and wastelands of the Islands and may therefore also help to disseminate the infection. In the Hawaiian Islands, the common habit of eating water cress has been regarded by Herbert[3] and Hall[4] as the most probable method of human infection. This has actually not been proved, although the danger does exist if water cress is grown in areas where the source of water used comes from localities contaminated by infected cattle or wild hogs and if lymnaeid snails are present. This is a local problem which requires further investigation.

[12] Alicata, J. E.: Longevity of Liver-Fluke Cysts, Hawaii Agr. Expt. Sta. Rpt. 1938:75, 1939.
[13] Swanson, L. E.: Surveys Show the Liver Fluke to be Widespread in the Hawaiian Islands, Hawaii Agr. Expt. Sta. Rpt. 1936:83, 1936.
[14] Swanson, L. E.: Slaughter House Reports of Beef-Cattle, Hawaii Agr. Expt. Sta. Rpt. 1936:84, 1936.
[15] Shipley, A. E.: Entozoa, Fauna Hawaiiensis, 2:427, 1913.

Therefore, preventive measures against fasciolid infections consist in avoiding uncooked vegetation grown in possibly contaminated areas and drinking from possibly infected streams. Basically, however, the problem of human prevention lies in the proper control of the flukes in cattle, which constitute the main origin of infection. This can be done by treating infected animals and by the use of chemicals in streams and swampy areas to destroy lymnaeid snails known to serve as the intermediate host of the parasites.

## Summary

A summary has been made of 19 cases of human fascioliasis which are known to have occurred in the Hawaiian Islands. Of these, 3 cases had not previously been reported.

In all the above cases, the flukes have been found accidentally during surgical operations or in other unexpected ways in the following portions of the body: liver, 4 cases; peritoneal cavity, 5 cases; respiratory passages, 4 cases (through sneeze, 2, and through cough, 2); ear canal, 1 case; skin lesion, 2 cases; unrecorded localities, 3 cases. These findings lead to the belief that other cases have occurred and have been unrecognized.

Some of the flukes involved in human infections have definitely been shown to represent species of Fasciola gigantica. The others are believed to represent this species on the basis of its prevalence in local animals.

Cattle in the Hawaiian Islands are commonly infected with F. gigantica and only rarely with F. hepatica. Flukes found in man are believed to originate from flukes found in cattle and possibly also from wild pigs.

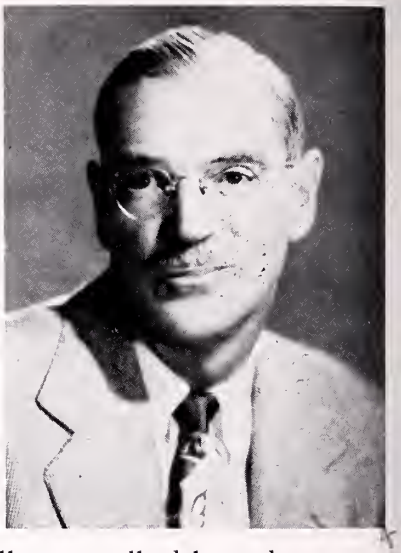
Human infections are believed to take place mainly by ingesting live encysted cercariae attached to vegetation grown in water or by drinking from streams containing floating encysted cercariae. Since water cress is the main item grown in water in the Islands and is eaten raw, it has been suggested by some writers that it may be the major source of human infection. Although there is no proof at the present time to substantiate this belief, such possibility does exist if water cress is grown in areas exposed to infected animals and if there are lymnaeid snails present.

Human protection against fascioliasis consists in avoiding eating uncooked vegetation grown in possibly contaminated areas or drinking from possibly infected streams. Basically, however, the elimination of human fascioliasis as a public health problem rests in the control of liver flukes in cattle and in the destruction of the fresh-water snails which serve as the intermediate hosts.

## Acknowledgment

The writer wishes to acknowledge the assistance of Dr. E. A. Fennel in supplying information for some of the above case histories.

The University of Hawaii



# *The President's Page*

## MEDICINE IS MY BUSINESS

The average business man does not hold the average doctor's financial acumen in the same repute as his professional ability. Physicians have the reputation of handling their monetary affairs rather poorly. They usually accumulate respectable sums in the form of outstanding accounts. Office management and collection of bills are usually delegated to a secretary. Inexperience in the investment world is frequently demonstrated and in other ways the evidence is often against the doctor.

Several factors not present in other vocations enter the picture. Expensive illness may strike the least prepared. They cannot be denied medical assistance with the same calculation as the banker's loan. Medical practice is usually dependent upon the good will of the patients; the use of sound business principles, when forceful, boomerangs with ill will. It is a contagious ill will that infects the patient's friends—the doctor's potential patients. Obligations to the landlord, the butcher, the baker and the grocer have priority. Income may cease when disability begins.

We are offered assistance in many forms. Collection agencies are skilled in the psychology of the take. Insurance programs collect payments for sickness before it occurs. There is a growing tendency, as in our Hawaii Medical Service Association program, to allow the doctor to have some voice in his own business. Management and labor are willing to hire us with salary or by the hour to save us the task of collecting our accounts. Government has plans to help shoulder our responsibilities for us.

In this changing world there is a change in the attitude toward medicine. People wish the security of medical care; they want complete protection. They are willing to budget definite amounts at regular intervals to pay for this security. Contracts are formed with individuals or groups at a price that assures them protection for amounts they specify. The squeeze play is on; the physician who turns down these contracts actually bids goodbye to a part of his clientele. While they cannot always consult the physician of their own choice, they value their medical security more.

I had a dream. In this dream all the doctors in the Territory decided to handle their own affairs. All contracts were made by the Hawaii Territorial Medical Association. Everyone was attended by the doctor of his choice. Every doctor charged fees for services. Payment was paid by doctors to doctors on a percentage basis depending upon what funds they had on hand from contracts. Contracts were made with the government for the indigent, with management for their employees, and with any group desiring medical assistance. There was bargaining for professional services. The doctors were making decisions as to whether or not they chose to work for any particular group. Here in this dream the doctors were running their own business!!!

And then I woke up.



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# [EDITORIALS]

## AMERICAN FEDERATION OF MEDICAL CENTERS

A nation-wide system of "community medical centers"—closed-panel group prepayment plans—is the avowed goal of the American Federation of Medical Centers, recently founded in Detroit, Michigan, by Dr. Edward H. Norris.

These organizations will be "baby Permanente" affairs, usually without hospitals. They will be financed—*and run*—by lay boards of trustees, who will receive monthly premiums of between 4 and 8 dollars per subscriber and from these will pay the salaries of staff physicians, nurses, technicians and other personnel, as well as maintenance costs. Existing hospital facilities in the community will be utilized through Blue Cross insurance.

The probable eventual elimination of private medical practice by such plans is foreseen by the Association of American Physicians and Surgeons, whose President, Dr. Charles L. Farrell of Rhode Island, recently published a thoughtful critique of the AFMC program. His objections are as follows:

1. Comprehensive medical care is prohibitively costly on any basis.
2. In any event, costs — and premiums — would vary widely in different parts of the country.
3. Doctors in groups are not likely to be uniformly acceptable to patients: i.e., a patient might like the internist and obstetrician, but not the surgeon.
4. Medical groups do not function harmoniously on a salary basis unless the doctors are working together in their own business enterprise.
5. *Usage* of medical prepayment plans is unpredictable (and might be excessive) even though incidence of specific illnesses may be foretold with reasonable accuracy.
6. Such group formation is unnecessary because doctors nowadays are rarely forced to work alone, as the AFMC brochures state.
7. Hospitals are private corporations for the most part, and the AFMC program would *not* help to get doctors admitted to hospital staffs.
8. Turning over the control of such a medical care program to the laity is an invitation to them to dictate the methods, and means of control, of medical practice.

In summary, Dr. Farrell concludes, the AFMC proposes regimentation of the medical profession by the laity, increasing dominance of hospitals over the medical profession, a plan unprotected against over-utilization of its static facilities, and finally—and perhaps most cogently of all—a plan which overlooks "the fact that doctors and patients are essentially 'human beings' and do not fit into a scheme based on the philosophical ideal."

Closed-panel group prepayment plans—nationally no less than locally—pose a far more realistic threat to solo private practice as we know it today, than does national compulsory health insurance. That they can succeed has been amply demonstrated in California, where half the doctors engaged in group practice are in the ten groups with a prepayment plan.

If AAPS is correct in believing that such groups are likely to eliminate private fee-for-service practice, it behooves every physician to take a serious interest in the AFMC program and familiarize himself with the arguments for and against it. If a change is to be made, we physicians should be the ones to initiate it, guide it, and operate the new program. Read Dr. Arthur Masters' article on the HIP of Greater New York in the October 25, 1952 issue of the *J.A.M.A.*, if you have not already done so. Read the Weinerman Report, with its recommendations for Hawaii. Inform yourself as fully as possible. Perhaps it's later than you think!

# THIS IS WHAT'S NEW!

A trio of papers by Haight and Finland covers **Erythromycin** exhaustively. They found that the new antibiotic is more active in alkaline solutions and is not inhibited by pus, serum and similar impediments. Bacteria do not produce Erythromycin inhibitors. Resistant organisms can be produced, Staph aureus being very prone to become resistant, but cross-resistance with 8 other antibiotics did not occur. Tests on over 1,000 bacterial strains showed high activity of Erythromycin against gram-positive cocci, Neisseria, diphtheria and Hemophilus, and no effect on coliform bacilli.

As to the mode of action, they concluded that Erythromycin may be either bacteriostatic or bactericidal, depending on the sensitivity of the organism and on the concentration of the antibiotic. Erythromycin exerts its effect only against actively multiplying bacteria (much like penicillin, and therefore combination with bacteriostatics like terra- and aureo-mycin would seem contraindicated). (*Proc. Soc. Exp. Biol. & Med.* 81:175-193 [Oct.] 1952.)

Anecdote re antidote: It has been shown that the extremely stable Vitamin $B_{12}$ (cyano-cobalamin) results when the hydroxo group in **vitamin $B_{12a}$ (hydroxo-cobalamin)** is replaced by a cyanide group. Mushett, et al. wondered about $B_{12a}$ versus **cyanide poisoning.** It exceeded expectations. They found $B_{12a}$ capable not only of preventing death when given before a lethal dose of cyanide, but also of reversing the effects of cyanide in "apparently dead" mice (in respiratory arrest). (*Proc. Soc. Exp. Biol. & Med.* 81:234 [Oct.] 1952.)

**Aureomycin** and **vitamin $B_{12}$** (alone, and even better together) were found by Meites to **prevent severe side reactions to cortisone** in animals (such as inhibition of body growth, alopecia, and thymic atrophy). This may help explain the spectacular results recently reported for the cortisone-terramycin combination in patients with fulminating viral hepatitis. (*Proc. Soc. Exp. Biol. & Med.* 81:307 [Oct.] 1952.)

**Procaine amide** (Pronestyl) 1.0 gm. four to five times daily controls symptoms in **Huntington's chorea,** a hitherto uncontrollable disease, according to Goldman. (*Am. J. Med. Sci.* 224: 573 [Nov.] 1952.)

Further Report: **Procaine in methylcellulose,** 300 mg. per dram, has been found useful in relieving spasm and pain in many gastrointestinal conditions, such as **cardiospasm, esophagitis,** and **hiatal hernia,** by Balfour and Wharton. (*Gastroenterol.* 22:257 [Oct.] 1952.)

Another follow-up report: **Heparin,** 100 mg. I.M. twice weekly relieved **angina pectoris** in 55 per cent of 29 patients who were unrelieved by all other therapy. Heparin therapy reduced the amount of Sf 12-20 lipoproteins in the blood, and resulted in improved ballistocardiograms. (Engelberg, *Am. J. Med. Sci.* 224:487 [Nov.] 1952.) One explanation: heparin may reduce sludging, not of RBC, but of large lipoprotein molecules on the intimal surface. "Cleansing" of the surface leads to better oxygen exchange through the intima, and therefore relief of angina.

**"Stigminene Bromide"** (chemical name and formula not given) was administered intramuscularly in 1 mg. doses daily for three days to 49 **women who wondered.** In 34 the overdue menstrual flow appeared, and in 13 of the 15 in whom no flow occurred, pregnancy was soon obvious. (Decker, *Am. J. Obst. & Gynec.* 64:1137 [Nov.] 1952.) One wonders if administration with a long needle into the gluteus maximus of lyophilized extract of Old Galoshes would not be just as accurate a "pregnancy test."

Virkkunen reports rapid improvement following **cortisone** therapy in 4 patients who developed **agranulocytosis** and **thrombocytopenic purpura** as complications of gold and thiosemicarbazone treatment of rheumatoid arthritis. (*Arch. Int. Med.* 90:580 [Nov.] 1952.)

C. A. Domzalski, Jr., M.D.

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Green, H. D., ed. *Shock and circulatory homeostasis.* Transactions of the 1st conf., Oct. 22/23, 1951. c1952. (gift of Josiah Macy, Jr. Foundation).

Hermann, G. R. *Diseases of the heart and arteries.* 4th ed. c1952. (gift of publisher).

Hamby, W. B. *Intracranial aneurysms.* c1952. (gift of publisher).

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Burrows, Harold. *Oestrogens and neoplasia.* 1952. (gift of publisher).

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American Goiter Association. *Transactions . . .* 1951. c1952.

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Bachman, G. W. *Health resources in the United States.* c1952. (gift of publisher).

Institute for Medical Research, Federation of Malaya. *Studies from the Institute . . .* Jubilee volume No. 25. 1951. (gift of the Institute).

* * *

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# BOOK REVIEWS

## This is Your World.

By Harry A. Wilmer, M.D., Ph.D. in Path., 165 pp., Price $5.50, Charles C. Thomas, 1952.

In many respects this is a unique book which may not be evaluated by using ordinary standards. Its author sets out to found a philosophy, describe a new technic and supply some of the basic materials which must be used with this technic.

His book is apt to be considered frivolous by the page-turner because of the free use of both verse and cartoon drawings. Those who grant the author the elementary courtesy of attentive reading will find him a source fortifying many old and well tried ideas and singularly rich in new and stimulating ones.

The world of "This is Your World" is that of the tuberculous sanatorium patient and it is an odd and in many ways a fascinating world. Dr. Wilmer describes and rationalizes it with the insight of the former patient who has become a psychiatrist and teacher. "Much of the practice of medicine," says the author, "is simply the relief of anxiety."

Dr. Wilmer has produced for his sponsors an original monograph of great value and deep significance in a field so barren of sober medical and psychiatric effort as to challenge belief.

ROBERT N. PERLSTEIN, M.D.

## Kitchen Strategy.

By Leona M. Bayer, M.D. and Edith Green, 112 pp., Price $3.75, Charles C. Thomas, 1952.

Kitchen Strategy is well written, succinct and easy to follow. However, it seems to have limited value in Hawaii.

The book does give a family angle on nutrition as many cook books do not. However, the family following this advice needs more than the average income and more than the average formality of living. The menus are distinctly not low in cost. An additional disadvantage in Hawaii common to most mainland books, is that there is no mention of any island foods and of course no attention paid to the varied and excellent racial foods that lend so much interest and variety to our meals in Hawaii.

Some of the nutrition information is misleading. For example, dried apple and pineapple found a place in the list of foods high in iron. Yet dried apples contain about one-fifth the iron in dried apricot, one-fourth the iron of dried figs, prunes or raisins. Pineapple is one of the lower sources of iron also.

For some homemakers, this book would be helpful, but there are other sources that would be even more practical for the majority of homemakers. Such a booklet is the U. S. Department of Agriculture's *Family Fare, Food Management and Recipes* which lacks only the few therapeutic diets included in Kitchen Strategy and costs only twenty-five cents.

MARJORIE G. ABEL, M.S.

## Oestrogens and Neoplasia.

By Harold Burrows, C.B.E., Ph.D., F.R.C.S. and Eric Horning, M.A., D.Sc., 189 pp., Price $6.75, Charles C. Thomas, 1952.

This book represents a vast amount of research on the endocrine factors involved in neoplasia. It is a good discourse on medical prevention of cancer. The work is presented in a very readable form and should be of interest to all physicians using hormones therapeutically. It will be of special interest to the gynecologist but is not limited to the female genital system in scope.

Estrogens have long been implicated as a cause of cancer. This is re-emphasized by the authors and it is stated that their indiscriminate or careless use may favor the occurrence of cancer in women. However, it is pointed out that the precautions necessary for the safe therapeutic administration of estrogens are clear.

The graduated pathological changes of estrogenic neoplasia are presented in a very clear manner. The stages of hyperplasia, innocent neoplasia, and malignancy described in estrogenic cancer may apply to other cancers, and thus this book may be considered a reference in studying the development of cancer in any site.

WALTER B. QUISENBERRY, M.D.

## Intracranial Aneurysms.

By Wallace B. Hamby, M.D., 524 pp., 193 illustrations, Price $14.25, Charles C. Thomas, 1952.

This concise and timely book will be welcomed by anyone interested in this fascinating subject. The author has condensed material covered in 700 publications in the world literature and has also drawn on his considerable personal experience. The excellent first chapter contains a quantity of material on the cerebral circulation in all its aspects.

The descriptions of the technics of diagnosing and treating all types of aneurysms, ruptured and unruptured, will appeal to physicians who are almost always the first to see these patients and on whom often falls the responsibility for diagnosis. The book is a convenient size with clear type and easy to read so one can give it a wholehearted recommendation.

JOHN J. LOWREY, M.D.

## Ophthalmic Plastic Surgery.

By Sidney A. Fox, M.S. (Ophth.), M.D., F.A.C.S., 290 pp., Price $15.00, Grune & Stratton, 1952.

This textbook contains a good collection of nearly all the possible plastic procedures that may be related to ophthalmic surgery. There is nothing entirely original as most of the technics and methods used may be found in other general plastic surgical textbooks. The illustrations are numerous and well presented. The bibliography is adequate. It should serve as a good reference book for anyone doing ophthalmic plastic surgery.

WAYNE W. WONG, M.D.

### Synopsis of Obstetrics.

By Jennings C. Litzenberg, B.Sc., M.D., F.A.C.S., Revised by Charles E. McLennan, M.D., Fourth Edition, 378 pp., Price $5.50, C. V. Mosby Company, 1952.

This book is aptly named, and will probably find its greatest usefulness in helping the medical student arm himself for a final examination, as a quick reference for the general practitioner who has no library facilities available in a hospital, or in instruction of nurses. Where any real detail is necessary, one should not use this book to find it. The author has listed, in 1-2-3 order, definitions, descriptions, treatments, procedures, indications and prognoses. He makes no attempt to go into detail and admits that one seeking such should use the larger textbooks.

In general his subject matter is well chosen and along the accepted lines of thinking in this field. As the author states, "the purpose of this book (is) . . . to provide an illustrated and somewhat amplified lecture outline for the medical student and for others needing a brief survey of the field of obstetrics."

ROBERT B. COCHRAN, M.D.

### Rare Manifestations of Metabolic Bone Disease.

By I. Snapper, M.D., 96 pp., Price $3.00, Charles C. Thomas, 1952.

This is a short book dealing with bone physiology, especially as related to hyperparathyroidism and multiple myeloma. Bone cannot be considered purely as mechanical nor a structure of calcium salts only. Certain diseases of the skeleton are manifestations of a disturbance of bone metabolism. Also calcium salts make up only 45 per cent of the skeletal substance.

This book is well written and is not cluttered up with experimental material. The author has done an excellent job of presenting the essentials of metabolic bone diseases in a clear and concise manner.

The binding is good. The book on the whole is easy to read and adequately illustrated, and should appeal to all doctors who want an excellent and up-to-date review on this subject.

B. ALLEN RICHARDSON, M.D.

### Sterility.

By J. Jay Rommer, M.D., 427 pp., 259 illustrations, Price $12.50, Charles C. Thomas, 1952.

Physically, this book on sterility is well bound, and the type is easy on the eyes. Some of the illustrations are very instructive.

The contents are detailed in a few places and very general in others. As the author states, his purpose in writing this book is to give one a complete coverage of sterility in all its aspects. This he carries out in his book, even down to the historical background and anatomy and embryology of the female genitalia. However, it is somewhat difficult to separate the wheat from the chaff.

He stresses his so called stick test, or cervical excursion test, which many men don't agree with.

In summary, this book makes a good addition to the library but does not contain any new information for the student of sterility.

JAMES T. S. WONG, M.D.

### Diseases of the Heart and Arteries.

By George R. Herrmann, M.S., M.D., Ph.D., F.A.C.P., Fourth Edition, 652 pp., Price $12.50, C. V. Mosby Company, 1952.

This textbook of cardiovascular disease is an attempt to cover the field in a brief yet thorough manner. The attempt is achieved in most instances. This fourth edition has been largely rewritten and includes most of the modern concepts of pathological physiology and treatment. It is not as comprehensive as many such textbooks and this perhaps is an advantage. Like many others it is deficient in two instances, namely, the management of congestive failure in surgery and obstetrics, especially the latter. The pregnant mother with heart disease is always a difficult problem and the subject is badly neglected in most textbooks. Some of the most interesting and valuable material of this book is in the appendix, which seems odd, to say the least.

J. B. BELL, M.D.

### Health Resources in the United States.

By George M. Bachman and Associates, 344 pp., Price $5.00, The Brookings Institution, 1952.

This study, compiled for the Brookings Institution, contains material of great value to public health administrators and all other persons concerned with community health conditions and planning. It has been used as major source material for certain congressional committees.

It is a reference type of volume and not one that would ordinarily be read through from cover to cover, but the tables are clearly presented and the explanations of them written in a lucid and interesting manner.

Certain definite trends in health conditions and health programs throughout the country become clearly evident in studying this volume. For instance, a very great increase in the number of auxiliary health personnel during the past decade, as compared with minor increases in the number of physicians and dentists, indicates a trend of giving improved health services by having the physicians and dentists make use of more well-trained assistants rather than having large increases of these two professional groups.

As is frequently the case in national studies, no figures are given for Hawaii, although these are readily available.

C. L. WILBAR, JR., M.D.

### Medical Public Relations.

By Edgar A. Schuler, Ph.D., Robert J. Mowitz, Ph.D. and Albert J. Mayer, Ph.D., 228 pp., Health Information Foundation, 1952.

On August 1, 1925, the Medicine Service Bureau of the Academy of Medicine of Toledo and Lucas County was inaugurated as an aid to citizens in time of need. Originally the Bureau provided a telephone answering service for physicians and an emergency call service. Twenty-five years later, in 1950, a full fledged public relations program was developed with the Service Bureau as its nucleus. This program centered about five areas: 1) a telephone switchboard Service Bureau for locating emergency medical help at any time, day or night; 2) a plan for helping people establish a regular family-doctor relationship; 3) preparation and distribution of a pamphlet entitled, "Getting Well at Home," which

was intended "to codify home nursing procedures and to promote better understanding between the home nurse and the family physician"; 4) a Speakers Bureau intended not only to supply qualified speakers on approximately 80 medical topics, but by a "method of indirection . . . (to convince) the public of the unnecessary and entirely dangerous character of any kind of regimented medical practice"; and 5) establishment of "a professional relations committee . . . with power to judge and suggest appropriate action" in order locally to "put teeth into the rules which cover the moral and economic ethics of good medicine." This program, in the judgment of the American Medical Association Public Relations Department, was among those deserving nationwide attention, and this it has received.

The Health Information Foundation, a voluntary scientific Information Foundation granted funds to Wayne University to work with the Academy of Medicine in evaluating the public relations program. This book is the result of their studies. Historical aspects of the program and analyses of doctor, leadership, and general public response are presented. A lengthy appendix elaborates technical aspects of the survey and presents sample advertisements used by the Academy.

The book should serve as a useful tool in aiding other medical societies in evaluating their Public Relations Programs. The individual physician should find study of the non-technical aspects of the report both interesting and profitable.

SAMUEL D. ALLISON, M.D.

## Physiological Bases of Gynecology and Obstetrics.

By S. R. M. Reynolds, M.A., Ph.D., D.Sc., Dr. hon. causa., 153 pp., Price $5.50, Charles C. Thomas, 1952.

This excellent monograph contains lectures given on the post-graduate level for physicians at the Facultad de Medicina de Montevideo. The subject is covered in its entirety, and yet the presentation is such that the reader does not lose interest at any point.

This book is not intended for the student of physiology, but for the busy clinician who does not have the time for detailed reading. What makes this book all the more desirable is that much of the work described is recent and the reading of this monograph brings one up to date without the need of combining the journals on the subject. There are few references and no bibliography.

This book will be equally enjoyed by the general practitioner and the specialist.

GAIL G. L. LI, M.D.

## Immuno-Catalysis.

By M. G. Sevag, Ph.D., Second Edition, 524 pp. with 24 tables, Price $12.00, Charles C. Thomas, 1951.

This technical volume is of no immediate value to the practicing physician. However, to the bacteriologist, biologist, and immunochemist, the book presents a rather plausible hypothesis and relates some clinical and physiological phenomena to this. A tremendous amount of work has gone into the book, and there is a large reservoir of references.

Physically the book is well bound, the cover is sturdy, and the print is large and easily readable. This book may in time be considered as a standard pioneering work in immunochemistry.

W. HAROLD CIVIN, M.D.

## Essentials of Infant Feeding for Physicians.

By Herman Frederic Meyer, M.D., 252 pp., 13 illustrations, Price $6.75, Charles C. Thomas, 1952.

In the past the problem of infant feeding has been quite empirical. The great advances of the present time and claims made commercially add confusion to the pediatrician as well as to the general practitioner of medicine.

This textbook will help the reader to clear up such confusion and is a valuable guide to the modern practitioner when he is confronted with the acceptance of proprietary infant foods.

I found the text to be up-to-date and it is quite interesting. The principles of chemistry and physiology are well worth a review for any practitioner of medicine.

FRANCIS K. CHU, M.D.

## Zinsser's Textbook of Bacteriology.

By David T. Smith, M.D., Norman F. Conant, Ph.D., Joseph W. Beard, M.D., Hilda Pope, Ph.D., D. Gordon Sharp, Ph.D. and Mary A. Poston, M.A., Tenth Edition, 1012 pp., Price $11.00, Appleton-Century-Crofts, Inc., 1952.

This revision of a long recognized textbook of bacteriology is timely and welcome. The text is concise, authoritative and up-to-date. The chapters on the enteric group of bacteria, the viruses and mycotic infections will be found especially noteworthy, particularly for those who have not taken courses in bacteriology in recent years.

MAX LEVINE, Ph.D.

## Atlas of Tumor Pathology.*

Tumors of the Breast by Fred W. Stewart, M.D.; Tumors of the Mediastinum by Hans George Schlumberger, M.D.; Tumors of the Carotid Body and Related Structures (Chemoreceptor system) by Philip M. LeCompte, M.D.; Teratomas by Rupert A. Willis, D.Sc., M.D., F.R.C.P.

These works are part of a collective Atlas of Tumor Pathology by various authorities sponsored by the National Research Council and the Armed Forces Institute of Pathology. In all, 39 pamphlets will be produced.

These fascicles, as did the first two received, attempt to follow the general outline of these atlases, namely; a) designation of tumor giving preferred name and listing most important synonyms; b) a precise statement of its principal characteristics; c) natural history of the tumor; d) morphology of the tumor; e) differential criteria; and f) selective bibliography.

The basic purpose of these atlases is to serve as a guide to the identification of the neoplasms by carefully selected illustrations and to give a pictorial representation of the main structural variants which characterize the many kinds of neoplasms. All the volumes are successful in doing this, some to a greater extent than others. These fascicles would appear to be a *must* for the pathologist, an advisable collection for the internist or surgeon, and a valuable addition for the general practitioner.

The fascicles are of paper with a paper binding. However, perforations are present which allow for collection in a binder. The print is easily legible.

W. HAROLD CIVIN, M.D.

* Prepared at the Armed Forces Institute of Pathology.

### Radiologic Diagnosis of the Lower Urinary Tract.

By Donald E. Beard, M.D., William E. Goodyear, M.D., and H. Stephen Weens, M.D., 143 pp., 280 illustrations, Price $6.50, Charles C. Thomas, 1952.

This review of the radiologic diagnosis of the many diseases of the lower urinary tract is published in atlas form with clear and adequate short discussions of each entity touched upon. The procedures for the most part are urethrography and cystography. There are numerous exceedingly good illustrations of x-rays of the lower tract diseases covered. Though this method of diagnosis has been in use since the turn of the century, it has not found wide use in many communities. In many of the teaching centers where there is very close liaison between the urologist and radiologist, these procedures have become a must on the urological services. Frequently the injection of contrast media into the lower urinary tract shows pathology and gives information not found on direct visualization of the tract by the endoscope and cystoscope.

I feel that this text merits the attention of not only those in the field of urology, but also the radiologist and the general surgeon. The methods described are simple to perform and safe for the patient.

ANDREW L. MORGAN, M.D.

### Psychiatry and Medical Education.

Report of the 1951 Conference on Psychiatric Education conducted by the American Psychiatric Association and the Association of American Medical Colleges, 164 pp., American Psychiatric Association, 1952.

This book is a report on a complex five-day working conference of a distinguished group of medical educators, half of them psychiatrists. It is remarkable in that it preserves the spirit and attitudes of the group and also maintains brevity. Its main interest will be for medical educators, teaching hospitals and psychiatrists, although its message is basic.

The report denotes a conviction that the medical student and physician must have a wider integration of bio-social teaching and experience if he is to fulfill his responsibility to patients and community. The purpose of the book is definitely accomplished and the work of this committee will stand for years as a significant signpost in medical thought and education. The book also contains a fine bibliography on the psychosocial periphery of medicine.

ROBERT A. KIMMICH, M.D.

### Acute Peripheral Arterial Occlusion.

By William D. Holden, M.D., 66 pp., Price $2.35, Charles C. Thomas, 1952.

This small book offers little new but does present in brief and readable form our present knowledge of the treatment of disorders of blood vessels of both traumatic and degenerative types. Many limbs and even lives could be saved if every general surgeon could apply the knowledge contained to the emergency treatment of interruption of the blood stream, no matter what its cause. The book is definitely worth owning.

C. M. BURGESS, M.D.

### The Moral Theory of Behavior.

By Frank R. Barta, M.D., F.A.C.P., 35 pp., Price $2.00, Charles C. Thomas, 1952.

This book, which represents a laudable attempt by the author to develop a theory of mental illness based on principles of normal behavior laid down by Aristotle and St. Thomas Aquinas, and in harmony with the principles of the Catholic Church, purports to present a moral theory of behavior, from which treatment of certain mental disorders is said to be very simple in the hands of the author. While this reviewer recognizes the value of incorporating the moral approach in the treatment of certain psychiatric disorders, it is his opinion that Dr. Barta's presentation is somewhat complex and confusing. It is the reviewer's opinion, further, that it would be difficult for other physicians to follow this author's approach to treatment, with the success reported by him.

R. D. KEPNER, M.D.

### Textbook of Surgery.

Edited by H. F. Moseley, M.A., D.M., M.Ch. (Oxon), F.A.C.S., F.R.C.S. (Eng.), F.R.C.S. (C), 896 pp., Price $15.00, C. V. Mosby Company, 1952.

As a general text for surgery, this book has a very good format and presentation. It combines in one volume the works of men associated with McGill University, written in the modern two column style of medical texts. The authors' views follow closely those expressed by the writers of this continent. The reading is easy and the material up to date. The best part of this book is the way the subjects are presented, with a short historical background, the embryology and physiology, and the various aspects of treatment, of each particular disease entity. Although the drawings of the surgical technical aspects leave much to be desired, the anatomical pictures by Netter are excellent. This text compares very favorably with our American texts and is a good addition to any physician's library.

ROY TANOUE, M.D.

## Also Received

### Claude Bernard and the Experimental Method in Medicine.

By J. M. Olmsted and E. Harris Olmsted, 277 pp., Price $4.00, Henry Schuman, 1952.

### The Surgical Clinics of North America.

August, 1952, Mayo Clinic Number, pp. 981-1,271, figs. 300-390.

October, 1952, Johns Hopkins Hospital and Scott and White Clinic Number, pp. 1,273-1,562, figs. 391-486, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1952.

### Malaria.

By Paul F. Russell, M.D., M.P.H., 210 pp., Price $7.75, Charles C. Thomas, 1952.

### Living with Cancer.

By Edna Kaehele, 160 pp., Price $2.00, Doubleday & Company, Inc., 1952.

### The Medical Clinics of North America.

September, 1952, Boston Number, pp. 1,201-1,512, figs. 120-150, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Co., 1952.

# HMSA—Its Place in the Community

## Statistics and Morbidity Studies

J. R. VELTMANN, *General Manager*

The 5,500 claims received each month from doctors and hospitals are carefully analyzed, coded and tabulated to assist HMSA in improving its services and for the purpose of cost analysis. Each claim received is classified by the type of service rendered and is coded for morbidity studies in accordance with the United States Public Health Service "Manual For Coding Causes of Illness." All coded information is recorded by IBM machines and tabulated data is summarized each month and is available for statistical analysis at all times.

On an annual basis, a summary is published showing exactly how each benefit dollar was spent, and this summary is detailed to show the following classification of services:

*Medical Care*—Non-surgical services are coded by diagnosis and show the number of cases, number of office, home or hospital visits paid and the number of hospitalized cases, including the number of hospital days for each diagnosis. For example, in 1951 HMSA paid for 7,436 cases of naso-pharyngitis, totaling 17,365 office visits, 468 home visits, 1,013 hospital visits, 244 hospitalized cases for 1,038 hospital days, or an average of 2.5 visits per case.

*Surgical Care* (for accidents only)—Each operative procedure and surgical service, including x-ray, is classified in accordance with an established HMSA coding for surgical services. These statistics present incidence studies which are vitally important when considering fee adjustments between HMSA and the various medical societies. One of the high frequency surgical procedures is "Tonsillectomy and Adenoidectomy" for which HMSA paid 898 cases for 1,305 hospital days during 1951.

*Hospital Care*—In addition to tabulating hospital care by the number of cases and days for each diagnosis, a very detailed report is tabulated by hospitals to show the total number of hospital days paid during the year, and the amounts paid for each type of service rendered. These statistics are very important and show where each hospital benefit dollar is spent.

The 1951 report shows that HMSA paid one participating hospital the following:

| | |
|---|---|
| Room and Board | $ 65,673.00 |
| Operating Room | 18,170.00 |
| Anaesthesia | 12,775.00 |
| Laboratory Services | 7,032.00 |
| Drugs and Antibiotics | 9,898.00 |
| X-Ray and Radium | 2,219.00 |
| Maternity Care | 16,687.00 |
| Other Services | 6,262.00 |
| Total | $138,716.00 |

In addition to these morbidity studies, detailed statistics on group benefit utilization are maintained to show amounts paid for medical, surgical, hospital and maternity services. These group studies are perpetual and summarized annually for the Sales and Service department of HMSA. In order to keep the Board of Directors fully informed, monthly statistics are developed on each plan offered by HMSA, showing the monthly dues income and total benefits paid on an accrued basis. Experience is charted separately for group and non-group members, and is presented in chart form each month through a publication entitled "HMSA Performance Guide," which is distributed to Board of Directors and key HMSA personnel.

Great emphasis is placed on the proper recording and tabulating of our statistical data in order to maintain accurate figures for future use. HMSA's Statistical staff is guided by a quotation of Mark Kormes, Consulting Actuary in New York City "The best and most advanced statistical methods are of no value unless applied to correct and accurate basic information."

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*Are you active in community affairs? According to a New York physician, a man who serves his community faithfully not only as a doctor but as a citizen will "inevitably convince a thinking populace that physicians are vitally concerned with the public good . . . and that their thoughts on controversial subjects are of distinct import to all."*

# TERRITORIAL MEDICAL ASSOCIATION REPORTS

## COUNCIL MEETING

October 27, 1952 at 7:30 p.m.
Mabel Smyth Building

**Present:** Dr. Chung-Hoon presiding; Drs. Richert, Lee, Ito, Yee, Sanders (Maui), and Orenstein (Hawaii), also Dr. Wallis (Kauai), Dr. R. B. Faus, Dr. Wilbar, Dr. Quisenberry, and the following members of the Chronic Illness Committee: Dr. Yamauchi, Dr. Bennett, Dr. Okazaki and Dr. David Pang.

Dr. Chung-Hoon explained that he was presiding because Dr. McArthur's plane had been detained on its flight from the mainland.

**Chronic Illness:** Dr. Chung-Hoon said that the Chronic Illness Advisory Committee had presented a report at the last Territorial Annual Meeting containing two recommendations—one to enlarge the committee with the addition of county committees, and the other to ask the Governor to form a Chronic Illness Commission. The first recommendation was passed by the House of Delegates and has been put into effect. The Delegates voted against the second recommendation.

Dr. Yamauchi, chairman of the Advisory Committee on Chronic Illness, stated that we are faced with the growing problem of chronic illness. There is an increasing incidence of such disease as the age of the population advances and this presents new problems. There is a need for a new approach to the problems of control, home nursing, home care, institutional care and rehabilitation. Adequate facilities are lacking in the Territory. An adequate survey to determine the Territory's needs is necessary. A Governor's Commission would be made up of representatives from interested organizations who would study the whole problem and recommend action.

Dr. Bennett spoke about the prevalence of chronic illness, Dr. Okazaki about institutions for the care of the chronically ill, and Dr. Pang about home care. It was brought out that the Oahu Health Council and other agencies are interested in having such a commission formed.

There was considerable discussion of the committee's request that the Council recommend the formation of a Governor's Commission on Chronic Illness to be composed of members selected by the organizations interested in the problem rather than personally selected by the Governor. The chairman stated that he felt the Council did not have the right to override the action of the House of Delegates.

**Action:** Dr. Orenstein moved that the Council go on record as thoroughly approving the aims of the Advisory Committee on Chronic Illness and, if necessary, we ask for a special meeting of the House of Delegates to reconsider their previous action on a Governor's Commission on Chronic Illness. Such a Commission would be a study commission. If any legislation is introduced in the coming session of the Legislature creating a commission for study of the care of the chronically ill, the Territorial Medical Association would be in favor of such a Commission, if the aims and objectives were in line with the recommendations of the Chronic Illness Committee. This motion was seconded by Dr. Yee and passed with one opposing vote.

**Industrial Relations:** Dr. Chung-Hoon called on Dr. Faus to inform the Council of the problems confronting the medical profession and HMSA in relation to medical and surgical care of union members. Dr. Faus said the union plan proposes a health fund controlled by a committee with three representatives from labor and three from management. Dr. Faus thought the Medical Association should authorize a group to negotiate with labor and management. If HMSA provided such a plan, the participating doctors would have to sign. There would have to be provision for policing the plan.

A lengthy discussion followed concerning the union's proposal of a panel system of salaried doctors suggested by the Weinerman report, as opposed to free choice of physician. In considering the possibility of the doctors' underwriting a plan for union members, there was a strong feeling among the Council members that they were opposed to any special treatment of the proposed labor plan by HMSA which would provide benefits to the union members any cheaper than to the 60,000 present members of HMSA, because that would be unfair to the other HMSA members..

**Action:** Dr. Orenstein moved that the officers of the Territorial Medical Association appoint an Industrial Relations Committee, with members from each County Society, to make a thorough study of all contractual relations of the labor unions with various insurance companies and other types of medical contracts and report possible action to the Council and to the County Societies. The motion was seconded by Dr. Yee and passed unanimously.

There being no further business, the meeting was adjourned at 10:55 p.m.

SAMUEL L. YEE, M.D.
*Secretary*

## REPORT OF THE HAWAII DELEGATE ON THE AMA MEETING IN DENVER (1952)

The Sixth Clinical [interim or winter—ED.] Session of the AMA was called to order by the speaker at 10 a.m. on Tuesday, December 2. After the invocation and roll call, the annual General Practioner's Award was given to Dr. Travis of Jacksonville, Texas.

President Louis Bauer stated that small communities should improve their physical equipment in hospitals to attract doctors to practice there. He went on to say that there are too many specialists. We should have more general practitioners in training and we should explore the possibility of a change in the specialty board requirements to encourage men to take up general practice for two or three years before taking up a specialty. Grievance committees of local societies, Dr. Bauer said, should consist of men with enough backbone to eliminate high fees, demand for payment in advance, and other examples of unethical practice.

After this capital address came the reports of the Secretary, the Board of Trustees and the standing and special committees.

Later that day the three most important resolutions (in the opinion of your delegate) were introduced: (1) That the United States withdraw from the International Labor Organization; (2) That the AMA withhold at the present time approval of extension of the "doctor draft law," PL 779; (3) That a change in the present care of acute non-service disabilities in veterans' hospitals be made which will markedly cut down this procedure.

## The ILO

The ILO consists of 68 nations at the present time, including the United States. Among the objectives of this organization are many which tend to socialize not only medicine but other occupations. It merely requires the approval of 2/3 of the Senate to conclude a treaty with a foreign nation and we might, without careful thought, find ourselves subscribing to a socialized system. A Reference Committee on Legislation and Public Relations suggested that the resolution be disapproved so that the U. S. could (a) find out what was going on, and (b) perhaps influence the ILO. The argument which successfully defeated this point of view was given by Dr. Aleson of California, who stated that if a virgin were posted in a house of assignation she might not find out what was going on and she certainly wouldn't influence the behavior of her sisters.

## Doctor Draft Law

The doctor draft law was referred to the Committee on Medical Military Affairs. I attended the hearings of this committee for four hours. An impressive, skillful argument against extending the law was voiced by Dr. Russel V. Lee, the delegate from the Section on Military Medicine. This committee's report, which was approved, stated as follows: (a) The Council on National Emergency Medical Service and the Board of Trustees should keep careful note of the military requirements for doctors until the next session. (b) Physical examination requirements should be relaxed in regard to minor defects. (c) There should be an extensive campaign to recruit career officers in the military services. (d) The services should make the most economical use of doctors already in uniform. (e) A point system for induction should be established. (f) Priority III doctors should be deferred until Priorities I and II are processed. (In general, Priority I includes doctors who were trained under V-12 or ASTP or deferred to study medicine and have had less than 90 days' service. Priority II is the same as Priority I, but those who have had at least 90 days' service and less than 21 months. In Priority III are those who did not have active service subsequent to September 16, 1940.) (g) Special pay for medical officers should be continued.

The supplementary report of the Board of Trustees was accepted, the essence of which stated: "Resolved: That the House of Delegates of the American Medical Association withhold any action on the proposed extension of the Doctor Draft Law beyond its present expiration date until such time as more specific data and satisfactory answers to the questions outlined above are available, and that the House instruct the Board of Trustees to take appropriate action when it is deemed advisable."

The committee recommended that the State and Territorial Chairmen should be called in conference prior to the introduction of any new law regarding the draft of doctors.

## Veterans' Care

With regard to the third important resolution, i.e., non-service-connected disabilities, the House, after some consideration, heard a fervent plea by Admiral Boone, Chief of the Veterans' Administration, which in essence said, "If you remove acute non-service-connected disabilities from veterans' hospitals, you will not interfere with this program, you will destroy it." He urged extreme caution before the veterans' program of caring for patients and the interne training program be abolished. (It is the opinion of this Delegate, despite the eminence of Admiral Boone, that if acute non-service-connected disabilities continue to be cared for in veterans' hospitals, the practice of medicine as we know it today will eventually be destroyed.)

The Committee on Insurance and Medical Service recommended that non-service-connected disabilities, except tuberculosis and neuropsychiatric illness, should not be treated in Veterans' Administration hospitals.

After considerable debate, it was decided that the Veterans' Administration, American Legion, members of Congress and members of the AMA should sit down and attempt to work out some method of curtailing the care of non-service-connected disabilities.

## Miscellany

The House of Delegates passed a resolution sponsoring a Federal Department of Health.

Louis A. Buie, Chairman of the Council on Constitution and By-Laws, suggested there should be a thorough re-study of the code of medical ethics for the purpose of simplification. He stated that this code probably can never be written perfectly, that it is a guide and not a law, and that the controversial issues in it are few.

## Social and Scientific

The usual strenuous social activities of the House of Delegates continued unabated. The first evening a party in honor of President-Elect E. J. McCormick of Ohio was given by the Ohio delegation at the Brown Palace. Your Delegate arrived with 22 orchid leis which were presented to the wives of the Ohio delegation and others with the appropriate gesture.

The next evening I entertained persons from Honolulu—all I could find.

Mrs. Bennett has on file the arguments presented by the military with statistical charts of why they feel the present doctors draft law should be extended and also the supplementary report of the Board of Trustees on the subject, which has been mentioned above.

In conclusion, I spent one afternoon at the scientific exhibits, which was not nearly enough time. A new antibiotic, Magnamycin, by Chas. Pfizer, was observed with interest. Color television is certainly the method of the future for medical teaching. My only regret in attending this meeting was that I was unable to hear any of the scientific papers. I enjoyed very much the company of Dr. Robert Faus as roommate. He was busy with voluntary insurance plans and medical military matters. He so impressed the Program Committee of the National civilian defense agencies that they asked him to stay over and address a session in Kansas City of all state Chairmen of Civilian Defense the following week. I caught a glimpse of Robert Johnston, saw more of Art Molyneux and missed Joe Lucas. Fred Warshauer, formerly of Kahuku, was a welcome sight.

I wish to thank the Society for the privilege and pleasure of making this trip.

A. S. HARTWELL, M.D.
*Delegate*

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The Semi-annual Dinner meeting was held jointly by the Hawaii County Medical Society and the Woman's Auxiliary to the Hawaii County Medical Society at the Hilo Yacht Club, Sept. 25, 1952. After a short program a meeting was called to order at 10 p.m. by President, S. Kasamoto. Members present were: Drs. Bergin, Carter, M. L. Chang, M. H. Chang, Crawford, Haraguchi, Jenkin, Kaufmann, Loo, Steuermann, Tomoguchi, Willett, Edward Wong, Woo and Yuen. Guests included Drs. Palacio, Lauwi, Lambert of the Hilo Memorial Hospital, and Mosac of the Kilauea Military Camp.

A letter from Dr. C. Phillips was read requesting that he be kept on the active list of the society. In the matter of the dues, it was moved by Dr. Carter and unanimously approved that we return his check and he be made an Honorary Member of the Society.

A letter dated Aug. 29 was read from the Executive Secretary of the Hawaii Territorial Medical Association asking the Society to select a representative for the Territory Advisory Committee on Chronic Disease. Dr. M. L. Chang was appointed by the president.

Concomitantly Dr. Archie Orenstein was appointed by the president to represent Hawaii on the Radium Advisory Board.

The Hawaii Medical Service Association requested the approval of a new income clause for surgical patients which provided that the income group belonging to the $3,000-$4,000 bracket be raised to $3,600-$4,800. A motion was made by Dr. Carter, seconded by Dr. Crawford that we accept this new change. Unanimously approved.

The rest of the evening was turned over to the program committee. Dr. Henry Yuen acted as the M. C.

* * *

The 325th meeting of the Hawaii County Medical Society was called to order by President S. Kasamoto at the Seaside Club at 8:00 p.m., Thursday, October 30. There were 20 members present. Guests included Dr. M. Berk of the Medical Group, Mr. Veltmann of HMSA, and Drs. Palacio and Lanwi.

An application for membership from Dr. Robert Henderson of Hilo was referred to the Board of Censors.

The rest of the evening was turned over to the two main speakers, Dr. Morton Berk of Honolulu and Mr. Veltmann of the HMSA. The former spoke about the "Fundamentals of the EKG" and the latter of the present health plan of the ILWU in relation to the HMSA.

The meeting adjourned at 11:45 p.m.

* * *

The 326th regular meeting of the Hawaii County Medical Society was held on December 4, 1952, at 7:00 p.m. at the Staff Room of the Hilo Memorial Hospital with President S. Kasamoto presiding. The members present were: Drs. Bergin, Crawford, Kasamoto, Kaufmann, Kutsunai, Miyamoto, Okumoto, Ota, Tomoguchi, Willett, Edward Wong, Woo, Yamanoha, and Yuen.

Dr. Robert Henderson was accepted as a new member of the Society.

An application for membership was received from Dr. James Mitchell of Kealakekua, Kona.

A letter dated December 1 was received from the Hutchinson plantation requesting another waiver of "residence clause" for their new doctor, Dr. Richard Knotts. A lengthy discussion followed, and it was decided to grant it. However, in the interest of the Society, the following recommendations were made:

1. In the future, if any vacancies are available for a new doctor, the Society be informed before any action is taken by the plantation to hire a doctor from the mainland.

2. And if a waiver is to be granted, the doctor be advised that he must remain in Hawaii not less than one year or his membership in this Society will be revoked.

3. A letter dated November 10 was received from the Hawaii Heart Association asking the Society if we are interested in a Heart Clinic. No action was taken at this time.

4. A letter was received from Dr. Francis F. C. Wong, requesting a leave of absence for military service. He has been called back to active duty by the U. S. Navy. The request was granted.

5. A request for space to store emergency plasma and blood bottles by the Civilian Defense was granted.

RICHARD A. YAMANOHA, M.D.
*Secretary*

## KAUAI COUNTY MEDICAL SOCIETY

The regular meeting of the Kauai County Medical Society was held October 14, 1952 at the G. N. Wilcox Memorial Hospital, 7:30 p.m. The Vice-President, Dr. Clyde Ishii, presided. Members present were Drs. Wade, Boyden, Masunaga, Wallis, Kuhns, Goodhue, Cockett, Ishii, and Kim. Guest speakers were Drs. Hartwell and Waite.

The meeting was devoted entirely to the Postgraduate Session. Dr. Waite spoke on the Modern Management of Intestinal Obstruction.

Dr. Hartwell spoke on the Medical Aspects of Hypertension and discussed several forms of treatment.

The meeting adjourned at 10:00 p.m.

* * *

The regular monthly meeting of the Kauai County Medical Society was held November 11, 1952, at 7:30 P.M. at the G. N. Wilcox Memorial Hospital Library. The meeting was called to order by the President, Dr. Brennecke. Members present were Drs. Brennecke, Masunaga, Fujii, Ishii, Boyden, and Kim. Guests were Drs. Faus and Boudreau.

The following communications and correspondence were read and appropriate action taken as follows:

Letter from Mrs. Bennett re post-graduate session conducted by Drs. Hartwell and Waite stating that expenses were paid by the Straub Clinic with which they were affiliated. Secretary was instructed to write a letter of thanks to the Straub Clinic.

For the forthcoming short subject entitled "Your Doctor," the Secretary was authorized to release appropriate form letters and to use materials from the Public Service Committee.

Some of the members expressed the desire for the HMSA to distribute the recent pamphlet received from the office entitled "Your Money's Worth in Health" (by AMA) to a wider area, such as the plantation and union groups.

A letter from Mr. Veltmann of the HMSA was read regarding the proposed change in the current HMSA income clause of $3,000 for a single member and $4,000 for a combined family income to $3,600 and $4,800 respectively. Action: On motion by Dr. Fujii and seconded by Dr. Boyden, the proposed change in the income clause was unanimously passed by this Society.

There being no further business, the meeting was turned over to Dr. Faus who spoke on the significance and problems facing the medical profession if the Weinerman report were to be fully adopted.

* * *

The regular monthly meeting of the Kauai County Medical Society was held December 9, 1952, at 7:30 P.M. at the G. N. Wilcox Memorial Hospital Library. The meeting was called to order by the President, Dr. Brennecke. All members were present,

Dr. Brennecke read a letter from Dr. McArthur, President of the Territorial Medical Association, requesting a list of physicians to represent the local Society on the various Territorial committees. The following actions were taken:

| | |
|---|---|
| Industrial Relations Committee | S. Wallis |
| Cancer Committee | M. Brennecke |
| Diabetes Committee | B. Wade |
| Emergency Medical Service Committee | B. Wade |
| Hawaii Medical Journal | P. Kim |
| Radium Advisory Committee | K. Fujii |
| Legislative Committee | W. Boyden |
| Postgraduate Committee | M. Brennecke |
| Scientific Works Committee | P. Kim |
| Advisory Committee on Chronic Illness | K. Fujii |
| Advisory Committee for the Woman's Auxiliary | J. Kuhns |

Dr. Wallis informed the group that there will be a meeting of the House of Delegates soon. He pointed out that the major topic for discussion will probably be on the subject matter of chronic illness and the recommendations made by the Advisory Committee on Chronic Illness at the last Hawaii Territorial Medical Association's Annual Meeting in May 1952. There were some questions as to whether the extent of the problem on Kauai warranted a survey. Some members thought that as far as Kauai was concerned, it was not a major problem. Other members thought that a survey to determine the extent and nature of the problem should be done. Dr. Wallis made a motion to the effect that this Society go on record approving the appointment and formation of a Commission on Chronic Illness. This was seconded by Dr. Cockett. The motion was lost by the following votes: 4 Yes, 5 Noes, 3 Not Voting.

Dr. Kim informed the members that there will be a Chest X-ray Survey in February. He was particularly desirous of knowing how the members felt on the follow-up procedure. On motion by Dr. Wallis and seconded by Dr. Ishii, it was unanimously voted that the private physician be notified on all suspicious tuberculosis cases and that, if no word was received to the contrary, the Chest Clinic would continue any diagnostic follow-up studies as indicated.

Dr. Kemp discussed the possibility of doing a tuberculin survey in the kindergarten and first grade group. She gave a brief discussion on Dr. Palma's visit to Kauai. It was pointed out that it could be of value in the case-finding program and that this would be in the nature of a pilot study. On motion by Dr. Goodhue and seconded by Dr. Kuhns, the Society unanimously voted to approve the project in principle.

PETER KIM, M.D.
*Secretary*

## HONOLULU COUNTY MEDICAL SOCIETY

The annual dinner meeting of the Honolulu County Medical Society was held on November 21, 1952, at the Oahu Country Club, with Dr. William Ito presiding and approximately 102 members and guests present.

An interesting program included Dr. Paul Gebauer, Dr. Tom Fujiwara and his vocalist, and Dr. Richard You with some mystics.

* * *

A regular membership meeting of the Honolulu County Medical Society was held on December 5, 1952 at the Mabel Smyth Building.

The program included Dr. Steele Stewart's account of his "Trip to Korea as Consultant to the Surgeon General," and some interesting talks on "Pearls" gathered on recent sojourns to the Mainland by Drs. Strode, Bowles, Arnold Jr., and Nils Larsen, and an appeal to the Society members by Mr. E. E. Black, Chairman, Board of Directors of Queen's Hospital.

It was approved by the general membership that the Society renew its subscription of $250 to the Oahu Health Council for the year 1953.

The meeting adjourned at 9:30 to the lanai where refreshments were served.

C. W. BURGESS, M.D.
*Secretary*

## MAUI COUNTY MEDICAL SOCIETY

A dinner meeting was held at the Grand Hotel, October 14, 1952. Members present were: Drs. Ferkany, Underwood, Ohata, Izumi, Shimokawa, Toney, Tompkins, Burden, Cole, Sanders and Patterson. Guests were: Mr. Erling Wick (Chamber of Commerce), Mrs. Elizabeth James (HMSA), Mr. J. Veltmann (HMSA), Mrs. Anderson (Community Chest) and Dr. Mei (Department of Health).

President Burden introduced Dr. Mei who has just arrived on Maui to become Director of the Department of Health. He replaces Dr. Lathrop who left some time ago.

Mr. Wick was then introduced and spoke on the coming Community Chest drive. He in turn introduced Mrs. Anderson who is the chairman of the drive. She spoke briefly on community needs and the organizations supported by the Community Chest.

A short business meeting was then held at which time the following action was taken. Dr. Burden made the following committee appointments:

| | |
|---|---|
| Legislative Committee | Dr. Frank St. Sure |
| Post Graduate | Dr. Lester Kashiwa |
| Scientific Work | Dr. K. Izumi |
| Chronic Illness | Dr. Lester Kashiwa |
| Radium Advisory | Dr. John Sanders |
| HMSA | Dr. K. Izumi (to replace Dr. Toney) |

A request was made by HMSA to increase the limits of the minimum service fee from $3,000 to $3,600 for single persons and $4,000 to $4,800 for married persons.

It was then moved by Dr. Underwood, seconded by Dr. Patterson, that this request be adopted. Motion carried unanimously.

Mr. Joe Veltmann was then introduced and gave a financial report of the HMSA as of October 1, 1952. He spoke of some of the difficulties and troubles of the Association and how physicians could help to strengthen their position. He also spoke of abuses of the plan by some few physicians and urged that we provide by-laws in the Society for proper action against such physicians where necessary. In cases of fraud, the HMSA can take proper action but in cases of abuses of the plan, it is up to the Society to take action, inasmuch as the contract is between the individual physician and the Society. The HMSA has a contract only with the Society.

He then spoke at some length on the controversial subject of medical and surgical care of union members. This recently has been brought to the front by the Weinerman report to the ILWU and recommendations therein contained. All physicians can be vitally affected and there is the threat of the start of some form of socialized medicine for the entire community.

Following Mr. Veltmann's talk, a short movie on Intradermal Infiltration to Obliterate First Stage Labor Pains was shown.

* * *

The monthly meeting of the Maui County Medical Society was held at Central Maui Memorial Hospital on December 9, 1952. The members were invited to dinner as the guests of Dr. Wong, following which the formal meeting was held in the staff room.

Dr. Burden, President, presided at the meeting and the minutes of the previous meeting were approved as circulated.

A vote of thanks was tendered to Dr. Wong for the delicious dinner and refreshments. Some discussion was held as to the possibility of holding future meetings at this site in the staff room. It is very desirable because of the central location and the privacy afforded. Dr. Wong is to report on the possibility of doing this at the next meeting or before, to the President.

As a replacement for Dr. Wm. Toney as delegate of the Society, Dr. Sanders nominated Dr. Tompkins and this passed unanimously. He was then instructed about attending the Territorial Society Delegates Meeting to be held in Honolulu December 16.

A letter from the Territorial Medical Association president was then read, reminding us that replacements for Dr. Toney were needed on other committees. Dr. Kanda is to replace Dr. Toney on the Diabetes Committee and Dr. Ferkany is to serve as a member of the Industrial Relations Committee.

A letter from Mr. Eugene Sheffield was read, regarding the Prudential Insurance plan and its abuses. This letter had been sent to all physicians of the Society. Dr. Burden stated that he had answered this letter to the effect that the burden of education of patients should not be on the physicians but on the insurance company and management. If there is abuse of the plan, the insurance company should go directly to the physician concerned or turn over the evidence to the Medical Society for action. He also invited Mr. Sheffield to the January meeting to discuss the problem with the doctors.

Dr. Mei, head of the local Department of Health, announced the coming visit of Miss Winifred Devlin, Nursing Consultant of the Industrial Health Bureau, on Jan. 26. She is to hold a 5 day seminar in the evenings and will be available during the day for consultation, to any hospital, doctor or industry.

Dr. Mei also reported the occurrence of two polio cases last month and stated this may mean that we can predict early seasonal cases next year.

The meeting adjourned at 10:00 p.m., followed by a conducted tour of the new hospital for those who had not had an opportunity to see the institution before.

EDMUND TOMPKINS, M.D.
*Secretary*

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*One of the basic principles of good public relations, says the AMA, is the establishment of effective grievance committees by medical societies. Local medical societies must "police their own ranks and take disciplinary action against members guilty of unprofessional and unethical conduct. It's that one bad apple in the barrel that causes complaint. The medical profession prides itself on its high ethical standards and its dedication to serving humanity. It cannot afford to shelter the not-so-ethical man. Also, physicians who constantly over-charge should be firmly dealt with by their medical societies. Disciplinary action, when justified, strengthens the position of the profession in the eyes of the people."*

*Other effective public relations programs are the establishment of:*

*(1) A press-radio-TV medical code of cooperation.*
*(2) A Speakers' Bureau.*
*(3) A weekly radio forum on a health subject.*
*(4) A PR page in the monthly Academy Bulletin.*
*(5) Medical news and medical features in the local press.*
*(6) An adequate night and emergency call system.*

*Hawaii has good press-radio cooperation, a weekly radio forum, the availability of the* HAWAII MEDICAL JOURNAL, *and an adequate emergency call system. Each week the local press receives interesting health bulletins directly from the AMA.*

# NOTES AND NEWS

## PERSONALS

Back from the Mainland and foreign medical meetings are: **Drs. Laurence Wiig, Robert Millard, Harold T. Kimata, Robert Wong, L. Q. Pang, Philip Corboy, Peter Washko, Harold Moffat, Tadao Hata, Albert K. Ho, Joseph Palma, William Walsh, Isami Umaki, Clarence F. Chang, Homer Benson,** and **L. A. R. Gaspar.**

Attending the interim session of the A.M.A. at Denver were **Drs. Robert Faus, Robert Johnston, Joseph Lucas, A. V. Molyneux** and delegate **A. S. "Bill" Hartwell.**

**Dr. Nils P. Larsen** gave a series of three illustrated lectures on his recent European trip at the Honolulu Academy of Arts. The titles of these talks were "The Viking Nations," "The Roman Nations," and "The Trail of Ancient Man."

**Dr. Thomas M. Mossman,** city-county physician, has been awarded a certificate of merit by the Prudential Insurance Co. for "pioneering in the work of furthering child safety in the Territory of Hawaii." Last May Dr. Mossman sponsored a crusade in this area to educate parents to the dangers that "lurk in the home ready to kill or cripple youngsters." The program was conducted during a period proclaimed by Governor Long as Child Safety Week.

Back in Hawaii after a year's absence are **Dr. and Mrs. William A. Stevens** and their two sons. While on the Mainland Dr. Stevens worked in Chicago and Colorado Springs. He has opened his office with practice limited to psychiatry, in the Capitol Building at Waikiki.

**Dr. Herbert T. Hata** announces the relocation of his office at Rm. 212 King Kalakaua Building. He is a graduate of College of Medical Evangelists. Dr. Hata did graduate work in otolaryngology at the University of Pennsylvania. Between 1943 and 1946 he served in the U. S. Army.

**Dr. Norman R. Sloan** recently completed a six months' survey of leprosy in the Netherlands, New Guinea. Dr. Sloan's next assignment will take him to the Trust Territories of the Pacific Islands in a similar capacity.

**Dr. Philip Corboy** has been elected to lead IMUA (Hawaii Resident's Association, Inc.) in its fight against communism and all subversive and un-American activities during the coming year.

The Chang Clinic, 1408 Nuuanu Ave., announces the return to practice of **Dr. Wah Kai Chang.**

**Dr. L. Q. Pang** announces the association of **Dr. Herbert G. Pang.** Dr. H. G. Pang is a native of Honolulu. He is a graduate of Northwestern University Medical School and served his internship at The Queen's Hospital. He then spent several years studying ophthalmology at New York University Medical School, Jersey City Medical Center and Manhattan Eye, Ear & Throat Hospital. Dr. Pang is certified by the American Board of Ophthalmology.

**Dr. Raymond M. deHay** announces the opening of his office at 507 Uluhau Street, Kailua, with practice limited to internal medicine and gastroenterology. Dr. deHay is a graduate of the University of California where he also served a year's internship. He had a year's medical residency at The Queen's Hospital and an additional year at Leahi Hospital, also a year's residency in gastroenterology at the University of California, with three additional months at the same institution in internal medicine. Dr. deHay served in the U. S. Navy from 1946 to 1948. During this time he spent some time as instructor in the Institute of Tropical Medicine at Guam. He is married and has four children.

**Dr. Ralph Cloward** has been appointed regent of the Hawaii Chapter of the International College of Surgeons.

**Dr. Samuel D. Allison** recently returned from a trip to the Far East which took him to Taiwan, Hong Kong, Saigon and Manila. He served as a short-term medical consultant to the World Health Organization and was assigned to the Western Pacific Regional Office.

**Dr. Merton H. Mack,** kamaaina physician, returned to Honolulu after an absence of three years and opened his office at 382 Young Building. During this time Dr. Mack had a residency in general and plastic surgery at the University of Pennsylvania. His practice will be limited to plastic and maxillo-facial surgery.

**Dr. Clarence Fronk** recently returned from a trip around the world. In the United States he attended the International College of Surgeons meeting in Chicago, the meeting for the American Association for the Surgery of Trauma in New York and the meeting of the American College of Surgeons also in New York. He reached Africa by way of Ireland, France, Switzerland, Italy, Greece and Egypt. He writes: "We had directed our safari consisting of two heavy trucks, two light hunting cars, two white hunters and 18 boys, to proceed one week previously 700 miles south to Taboru, Tanganyika. We then proceeded 100 miles south to begin hunting and picture taking on the Angola River. With my outfit I returned to Taboru, entrained there over a narrow gauge railway and proceeded 300 miles west to Dodoma. From there I hunted my way northward to Kenya. We then left for India where most of my time was spent at Jaipore hunting. I also visited Bombay, Delhi, Benares and Calcutta. At Indore I addressed the faculty and students of the Indore Medical College. I returned to Honolulu by way of Bangkok, Hong Kong, Tokyo and Wake Island."

**Dr. Ralph Cloward,** who accompanied Dr. Fronk on his safari, writes: "After arriving in Africa, with my own white hunter and equipment I went on a photographic safari into the wildest and most primitive areas of Tanganyika and Kenya. We tracked, hunted and photographed all dangerous game, all plains game and had many dangerous and exciting experiences. On my return to Nairobi I was guest speaker of the East Africa Surgical Association where I read a paper on the Recent Developments of the Treatment of Low Back Pain. On November 1, we left for central and northern India. There we did much sightseeing, tiger hunting and photographing. We spent one week as guests of the Maharajah of Indore where I had an opportunity to address the Mahatma Gandhi Memorial College of Indore on

**SUPPLEMENT TO HAWAII MEDICAL JOURNAL**
**JANUARY-FEBRUARY, 1953**

DOCTOR: For a constant reminder of medical meetings in the year 1953, place this where you and your secretary can see it.

## HOSPITALS

### Children's
Manday—12:30 P.M.—weekly luncheon—case reparts
Friday—12:30 P.M.—manthly staff lunchean and meeting—4th Friday

### Kapiolani
Manday—12:30 P.M.—weekly—Radialagy, Ob. and Gyn. pathalagy seminar under Dr. K. S. Tam at St. Froncis Hospital
Thursday—12:30 P.M.—manthly staff—3rd Thursday

### Kuakini
Friday—5:15 P.M.—manthly
Dinner and staff meeting—2nd Fridoy

### Leahi
Friday—7:30 P.M.—Sincloir Club (Far study of chest diseases)
2nd Friday—monthly

### Queen's
Thursday—12:30 P.M.—monthly
Staff meeting and lunchean—last Thursday

### St. Francis
Friday—12:30 P.M.—monthly
Staff meeting and luncheon—3rd Friday
Monday—12:45 P.M.—weekly—Radiolagy, Ob. and Gyn. pothalagy seminar in canjunctian with Kapialoni Hospital

## TUMOR CLINICS

### Kuakini Hospital
Every ather month—2nd ar 3rd Wednesday—1:00 P.M.
Call Dr. Tilden, Phane 5-0901, to schedule cases

### Queen's Hospital
Bi-weekly—1st and 3rd Monday—12:45 P.M.

### St. Francis Hospital
Monthly—2nd Friday—8:30 A.M. under Dr. R. B. Chappell
Call Dr. Chappell, Phane 6-6171, ta schedule cases
Far Hame Nursing Cancer Service, call Dr. Quisenberry at 5-0511, Ext. 220
For Cancer Cytalagic Diagnostic Service, call 6-2336 far details

## SOCIETIES

### Honolulu County Medical Society
Monthly meeting—1st Friday—7:30 P.M.
Baard af Governors—Tuesday of week preceding above—4:15 P.M.

### Honolulu Academy of General Practice
2nd Tuesday—manthly—7:30 P.M.
Pres.—Dr. Jahn M. Felix
Vice Pres.—Dr. Rabert F. Bailey
Sec.-Treas.—Dr. H. Q. Pang

### Hawaii Dermatological Society
Meets at announced dates
Pres.—Dr. Harald M. Jahnson
Sec.-Treas.—Dr. Harry L. Arnald, Jr.

### Honolulu Eye, Ear, Nose & Throat Society
3rd Thursday—manthly
Pres.—Dr. C. W. Trexler
Sec.-Treas.—Dr. Todoa Hata

### Honolulu Obstetrical & Gynecological Society
3rd Manday—manthly—7:30 P.M.
Pres.—Dr. Lyle Phillips
Sec.-Treas.—Dr. James T. S. Wang

### Honolulu Orthopedic Society
1st Thursday—manthly—7:30 P.M.
Pres.—Dr. J. Warren White
Sec.-Treas.—Dr. Jahn W. Caoper

### Honolulu Pediatrics Society
3rd Thursday—manthly (closed)
Pres.—Dr. Richard Yamane
Sec.-Treas.—Dr. Clifford Kobayashi

### Honolulu Surgical Society
3rd Friday—alternate months (Jan., Mar., May, etc.)—7:30 P.M.
Pres.—Dr. R. G. Jahnston
Sec.-Treas.—Dr. Lester Yee

### Hawaii Territorial Medical Association
April 30-May 3, 1953—meets in Wailuku, Maui

### Territorial Ass'n of Plantation Physicians
Meets November 13, 14 and 15, 1953, an Malokai
Pres.—Dr. William Wilkinson, Lanai City, Lonai
Vice Pres.—Dr. Herbert Rothwell
Sec.-Treas.—Dr. Paul Caldwell

### Hawaii Chapter, Am. College of Surgeons
Meets at annaunced dates
Pres.—Dr. Steele Stewart
Sec.-Treas.—Dr. F. J. Pinkerton

### Hawaii Chapter, Am. College of Physicians
Quorterly dinner meeting—Feb., May, etc.—2nd Thursday
Annuol meeting—Atlantic City, April 9-15, 1953
Pres.—Dr. Nils P. Lorsen

### Society of Neurology & Psychiatry of Hawaii
Bi-manthly—2nd Wednesday—7:30 P.M.
Pres.—Dr. John Lynn
Sec.—Dr. Yan Tim Wong

### Radiological Society of Hawaii
Bi-manthly—3rd Fridoy—ploce os onnaunced
Pres.—Dr. Louis Buzaid
Sec.—Dr. Alexander O. Haff
Treas.—Dr. Philip S. Arthur

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the recent advancements in neurosurgery. I was also guest speaker at the Delhi Medical Association's monthly meeting. After a short but enjoyable visit in Kashmir and Benares we left for Bangkok where we were entertained by Prince Bera. I then flew to Manila via Hong Kong to attend the Philippine College of Surgeons' annual convention as honored guest of the College. I participated in the program and addressed the senior class of the Santo Tomas Medical College."

**Dr. Masato Hasegawa** has recently been certified by the American Board of Pediatrics.

**Dr. Robert Jay,** resident physician at the Kamehameha School, has been recalled to active duty in the U. S. Navy. He left for Japan in the early part of December. **Dr. Cyrus Loo** is on duty at Tripler. Other doctors who have recently entered the service include **Dr. Olaf Christofferson,** formerly a resident at Kapiolani, **Dr. Nobuyuki Nakasone,** now in the air force, **Dr. Walter S. Strode,** formerly with the Ochsner Clinic in New Orleans, **Dr. Francis F. C. Wong** of Hilo, **Dr. Francis K. L. Won,** formerly a resident at St. Francis, and **Dr. Richard Y. K. Wong. Dr. Keith Kuhlman** is close to the active fighting in Korea.

### Hawaii

**Dr. Francis F. C. Wong** has been called to active duty as of November 9 by the U. S. Navy.

**Dr. Robert Henderson** was approved for membership by the Hawaii County Medical Society.

Good luck to our new doctor at Kealakekua, Kona—**Dr. James E. Mitchell.**

**Dr. R. L. Knotts** has replaced **Dr. Willett** at Naalehu.

## NEWS

### GP's to Hear Specialists

General practitioners will benefit from the wide-ranging clinical and research experience of nationally known specialists from ten medical schools and eleven major cities, at the 17th Alumni Postgraduate Convention, sponsored by the Alumni Association of the College of Medical Evangelists School of Medicine, at the Ambassador Hotel in Los Angeles, March 8-10, 1953. In a crammed three-day program these experts from the West, Mid-West, and East will present in lectures and panel discussions what the general practitioner must know about the latest developments in medical practice and medical science.

### OFFICE SPACE

A new structure is rapidly being completed at 181 South Kukui Street, near Emma; this will be known as "The Medical Dental Building."

This building will provide an opportunity for doctors and dentists to have a suite in a modern office building that offers, under one roof, related services so desirable to the professions. At the same time, the tenant maintains his identity as an individual practitioner. There is abundant parking space.

The building is modern in concept, designed by Wimberly & Cook, A.I.A., architects and engineers, with special consideration for the needs of the medical or dental profession. Clinical laboratory, X-Ray and pharmacy services are available on the premises. Elevator service and spacious easy stairways lead to all three floors.

An architect's drawing of the completed building may be seen in the advertisement on the next page.

## CORRESPONDENCE

To the Editor:

For the past five years or so there has issued from the Department of Institutions a steady stream of press releases extolling the wonder of the Territorial Hospital, usually accompanied by derogatory references to the previous administration, which happened to be mine for almost ten years.

The latest example of misrepresentation appears in the September-October issue of the Journal in a communication from Robert A. Kimmich, M.D., Clinical Director, wherein he refers to the hospital of my time as an "outdated custodial institution." That statement is not true.

Here, briefly, are the facts, accessible to Dr. Kimmich had he not been misled:

The hospital was among the first to use Metrazol and Electric Convulsive therapy, and deep insulin coma. We actually pioneered in prefrontal lobotomy.

At the beginning, a large staff of physicians and psychologists was organized. Occupational Therapy and Social Service Departments were established and a liberal policy of trial home visits was put in effect.

In 1939 I prepared the laws to restore the hospital to medical control as well as new legislation to simplify admission and discharge, still in use I am told.

In 1943 I prepared and designed a new treatment unit, deferred by the war, but finally completed last year exactly according to my plan.

I am informed by reliable and loyal colleagues that the treatment program is now the same, no better or no worse, than it was several years ago.

Since I intend to return to Hawaii before long I ask for space in the Journal to correct the false impressions that have been created, not deliberately perhaps, yet no less damaging to my self esteem, a valued possession of every honorable man.

E. A. Stephens, M.D.
*Hollywood.*

Dr. Stephens' letter was submitted to Dr. Kimmich, who replied as follows:

Dr. Stephens states his position very well. However, it must be obvious that none of the references he mentions were directed at his personal abilities or aspirations. He does not give himself the credit of having started a program with enough vitality to continue its growth during the seven years he has not been with the hospital.

Robert A. Kimmich, M.D.
*Medical Director,*
*Territorial Hospital.*

# UMI MAKAHIKI I HALA*

**New Members**

**Clarence Y. Sugihara,** Marquette, 1941
**Clarence Fong Chang,** Rush, 1940
**Colin Craig McCorriston,** Harvard, 1939
**Francis Dean Nance,** Rochester, 1931
**Peter Henry Buck,** Otago, 1904
**George Francis Straub,** Heidelberg, 1903

The time for future meetings was again brought up. It was agreed that this be left to the officers, who should give some consideration to the time of the full moon.

The Society was notified by the OCD that the Military Governor had approved of physicians having brighter automobile headlights for night driving; ¼" x 2" slits, the same size as on police cars, may be used.

The Bureau of Maternal and Child Health of the Board of Health announces the inauguration of a program of financial aid for certain types of medical service to the dependents of military personnel. A limited amount of funds has been allocated by the Children's Bureau for use here. The program calls for subsidizing the costs of maternity care and pediatrics, including hospital costs and a limited amount of pay to the physician for his service.

It is interesting to note that OCD Director Black properly gives credit to **Dr. E. A. Fennel** as having proposed the establishment of a blood bank in Honolulu in December, 1940.

**Dr. W. D. Balfour** of Pahala was transferred to the Maui Society, as was **Dr. E. A. Tompkins** of Puumaile Home.

**Dr. W. F. Leslie** of Leahi Home replaced Dr. Tompkins as Superintendent and Medical Director of Puumaile Home.

**Dr. R. Eklund** succeeded **Dr. Balfour** at Pahala: he was in turn replaced by **Dr. L. R. Fernandez.**

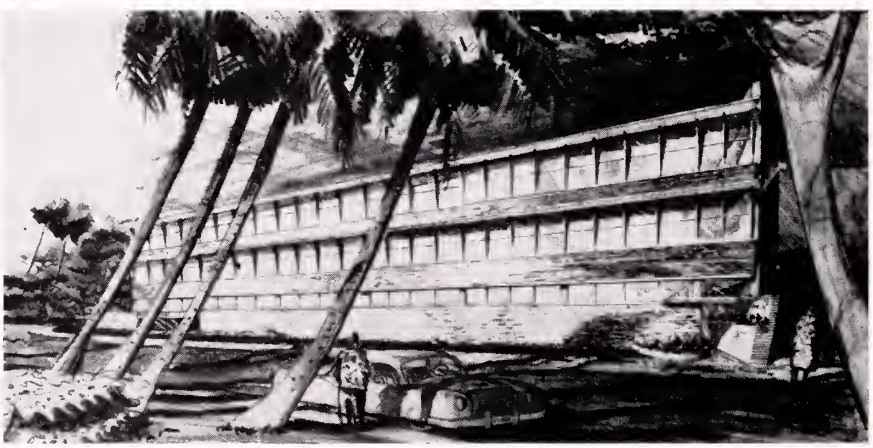
**Dr. R. P. Wipperman,** from Honolulu, is now at Naalehu, Hawaii.

Have you heard the broadcast of **Dr. Rodney West's** song "I Miss My Old Hawaii?" Both lyrics and music are by Dr. West. We have copies available.

**Dr. Homer M. Izumi,** Kula sanatorium physician, was the first American of Japanese ancestry to volunteer for the army in the Paia district.

* Ten years ago. From Volume 2, Number 3, January-February, 1943.


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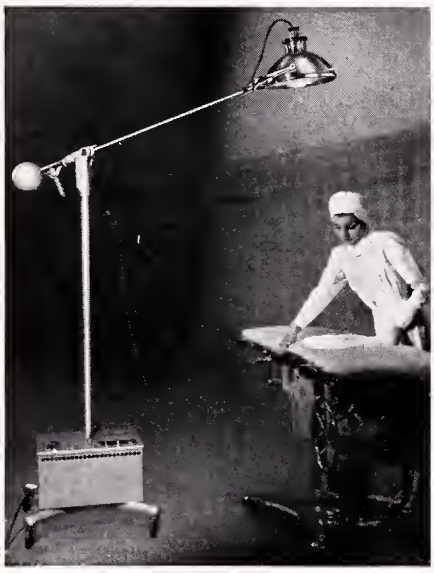
# New CASTLE Explosion-Proof Lights



## No. 40 SPOTLIGHT

**Adjusts Vertically by Internal Counterbalance and has easy horizontal mobility providing exactness in beam direction.**

## No. 51 -- SAFELIGHT



**This explosion-proof light has a conventional counter-balanced arm which permits positioning directly over the table but out of the way of the operating team.**



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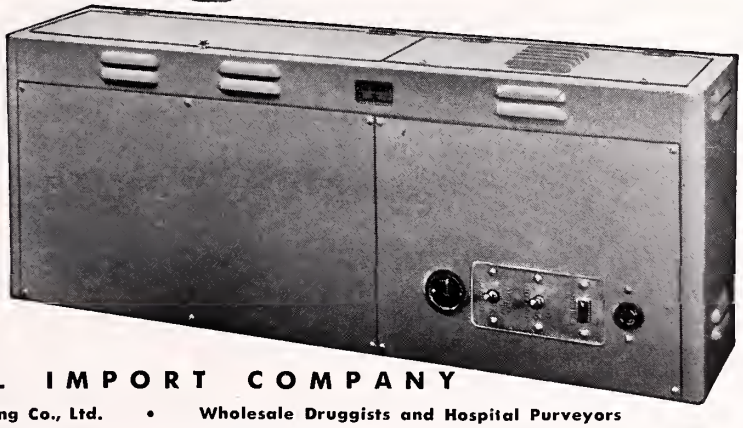
**Has 17 inch reflector. The lamp moves up and down 25 inches and has a 51 inch rotation radius.**

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## ABOVE 5′ DANGER AREA

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**Gives complete and automatic protection from power failure. This three-circuit system automatically keeps batteries in perfect condition. It immediately takes over the power load in case of failure.**



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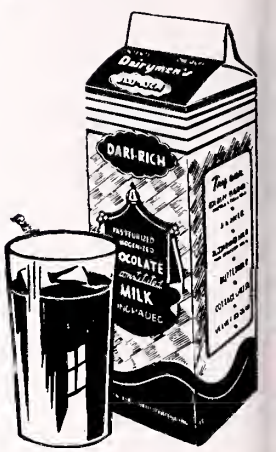
# Hawaii's Children

"Little faces looking up,
Holding wonder like a cup."



## Your big responsibility, doctor!

**So, when mothers bring you their problem of what to do, "Jimmy won't drink his milk," remember . . .**




# Dairymen's DARI-RICH CHOCOLATE MILK

*(Children just love chocolate milk!)*

**HOT OR COLD**
**Morning, Noon, or Night**
**Delicious, Nutritious**

**Made with real milk—whole milk, not skim milk! Made with real chocolate for delicious taste. Rich! Contains all of the butter-fat, all of the vitamins, minerals, protein of white milk.**



**Try some hot yourself, doctor. It sure is a lot more nutritious and soothing, than that third cup of coffee. You know that!**

*Note too: For further taste variety, Dairymen's also feature Strawberry flavored fresh whole milk.*

Dairymen's Association, Ltd., A Division of Creameries of America, Inc.

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAM, *Executive Secretary,* Honolulu

BULLETIN COMMITTEE

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## MESSAGE FROM THE PRESIDENT

Now, as in the past, the Nurses' Association, Territory of Hawaii, Inc., is faced with many problems, with many projects. It will be so in the future for we are a living, moving organization. Now we are feeling the effects of national reconstruction, of international nursing problems. We are an integral part of World Nursing. We symbolize peace and mercy. Yet, there is a flaw in our picture. What is wrong with us when more than half of the professional nurses in Hawaii do not belong to their own organization? Is the total blame to be placed on the Association? Those who take an active part in the Association say "No." Is the answer a clue?

We need more nurses who will take an active part in the Association. Each of you has great potentials. How much have you given to your own group of time and interest? Many hands are needed to help us function smoothly, efficiently and effectively. Will you help? Through active participation in your District Association, you strengthen y o u r Territorial Association. Through active participation on District and Territorial Committees, you operate the Nurses' Association, Territory of Hawaii.

There are many phrases which have become trite with use because they are apropos to every day situations. "In unity there is strength"; "United we stand, divided we fall"; "A chain is as strong as its weakest link" are familiar enough to be tiresome—but oh, so true. Let us work together for a strong organization. It will pay good dividends in the near and distant future. The honor of being the President of the Nurses' Association, Territory of Hawaii, Inc. does not obliterate the responsibilities the office imposes. The President is only your spokesman. The Association belongs to you. Make it the kind of Association YOU want.

ELIZABETH S. MCCALL, R.N.

## RESOLUTIONS ACCEPTED BY THE HOUSE OF DELEGATES OF NATH AT THE 21st ANNUAL CONVENTION*

*Margaret Jones*:

WHEREAS, A record of the founding and of changes in policy regarding the Margaret Jones Memorial Fund is necessary for proper handling of the fund now and in the future; and

WHEREAS, Miss Albertine Sinclair has provided the Nurses' Association, Territory of Hawaii, Inc. with such a record through painstaking search through old papers, and through organization of this material into a continuous whole; therefore be it

RESOLVED, That the House of Delegates, Nurses' Association, Territory of Hawaii, Inc. go on record as expressing gratitude for her generous contribution; and be it further

RESOLVED, That the secretary of the Nurses' Association forward a copy of this resolution to Miss Sinclair.

*Place of Convention*:

WHEREAS, Meetings held on neighbor islands are advantageous, 1) to Territorial membership as a whole and 2) to individual members of the county associations; be it

RESOLVED, That on odd numbered years the annual convention of Nurses' Association, Territory of Hawaii, Inc. be held on Kauai, Maui, and Hawaii in accordance with invitations extended, and on even numbered years in Honolulu.

* Courtesy resolution not included.

*Forty-Hour Week*:

WHEREAS, The 40-hour week is a stabilizing factor in employment; and

WHEREAS, The 40-hour week is generally accepted throughout the U. S. A. as the basic work week; and

WHEREAS, Experience has shown the 40-hour week to be a valid and effective method for meeting problems of staffing, recruitment and turnover of nurses; and

WHEREAS, The House of Delegates of ANA at the 1952 Biennial Convention endorsed the 40-hour week; therefore be it

RESOLVED, That the House of Delegates of the Nurses' Association, Territory of Hawaii, Inc. endorse the 40-hour work week, and in accordance with the provisions included in the resolution of the ANA House of Delegates; be it further

RESOLVED, That the House of Delegates of the Nurses' Association, Territory of Hawaii, Inc., calls on employers of registered professional nurses to put into effect the 40-hour week as the basis of payment for registered professional nurses, without reduction in salary, and with the request that employers make every effort to explore all such policies and practices as will make possible the institution of the five-day, 40-hour week, with two consecutive days off, as the standard work week for registered professional nurses; and be it further

RESOLVED, That any work by registered professional nurses beyond the 40-hour week be compensated on the standard basis of time-and-one-half; and be it finally

RESOLVED, That the House of Delegates urges every nurse, through her district association, to work for immediate implementation of the 40-hour week as set forth in this resolution.

## ACTIONS OF THE HOUSE OF DELEGATES 21st ANNUAL CONVENTION, NATH

*Accepted* the minutes of the 20th Annual Convention.

*Voted* that in the future minutes of the annual convention be read and approved by the Board of Directors.

*Accepted* the ballots as presented.

*Accepted* the recommendations of the Legislative Committee as NATH's legislative program for 1953. (See November-December Bulletin, page 137.)

*Referred* to the Commission on Nursing Education and Nursing Services the consideration of provision for promotion and help to the hospital schools of nursing.

*Accepted* the following recommendations of the Economic Security Committee:

1. That all territorial sections of the Nurses' Association consider the 40-hour work week recommended by ANA and study how the 40-hour work week will affect the nurses and their employers.
2. That the sections make a survey of existing personnel policies and follow through on them with formulation of personnel policies for their section.
3. That the sections make available to the executive secretary the personnel policies adopted by them to assist her in counseling and placement of nurses and to inform the employer of nurses the personnel policies set up by the Nurses' Association through its sections.

*Accepted* the recommendations of the Margaret Jones Memorial Fund Committee as follows:

That the Margaret Jones Memorial Fund be established as a trust fund with the Bishop Trust Company as trustee. That the fund be established for:

a. Direct gifts to nurses in case of emergency such as illness of the nurse herself or an emergency trip.
b. Loans to nurses for emergencies such as medical, hospital or dental care.
c. Direct gifts for educational purposes, such as, books for the library.
d. Loans for advanced nursing education.
e. Other collateral purposes.

That the eligibility requirements shall be:

a. A registered nurse who has belonged to the Territorial Nurses' Association for at least two years.
b. A new graduate nurse who is a member of the association for the current year may be granted a loan at the discretion of the committee.
c. The nurse must keep an active or associate membership in the association during the period of the loan.

That the maximum amount of the loan or gift should not exceed $500 unless approval is obtained from the board of directors of the Territorial Nurses' Association.

That 2% interest shall be charged on all loans.

That payments shall begin at the end of two years unless a longer period of time is granted by the committee for a special reason.

That not more than the income shall be expended in any one year for gifts or unpaid loans, and not more than 10% of the principal shall be loaned in any one year. If a larger amount is necessary, the approval of the membership must be obtained.

That further details involved in the establishment of the trust fund be entrusted to the committee and/or the officers of this association.

*Adopted* the policies for the use and maintenance of nursing material in the Mabel Smyth medical library as formulated and recommended by the Library Committee. (See this issue.)

*Adopted* a platform as a guide for the year's program. (See this issue.)

*Adopted* the budget as presented by the Finance Committee. (See INTER-ISLAND NURSES' BULLETIN November-December, 1952, page 136.)

*Accepted* the auditor's report for period January 1 to September 30, 1952.

*Voted* to charge a fee of five dollars ($5.00) for the collection of credentials in the Counseling and Placement Service for non-members of ANA, excluding graduates of less than six months.

*Voted* to raise dues for NATH from $17.00 to $18.00.

*Voted* to write a letter to the newspapers requesting that when advertising is accepted which states nurses' opinions that the NATH office be contacted for verification. This was precipitated by recent advertising stating that nurses approved the movie "Mom and Dad" which was not approved in the Territory either by nurses, doctors, or educators.

*Voted* to hold the 1953 Annual Convention on Maui.

## NURSES' POLICIES FOR USE AND MAINTENANCE OF MEDICAL LIBRARY

*Financing*: The Nurses' Association shall include in its budget annually so long as it is needed, a stated amount to be contributed to the en-

dowment fund of the medical library. It shall also include in its annual budget a definitely stated amount to be applied to the maintenance of the library. The board of directors of the Nurses' Association shall request annually of the Margaret Jones Memorial Fund an amount recommended by the Library Committee for new books, binding, renewal of periodical subscriptions and other necessities for making material useful to nurses.

*Use of Library*: Only those graduate nurses who are current members of the Nurses' Association, Territory of Hawaii, Inc. shall be allowed to borrow books, and only upon presentation of American Nurses' Association membership card. Rules for book loans shall conform to those set by the Governing Committee of the library. Guest cards at $1.00 per year are available to professional and properly qualified persons. Reading privileges in the library are available to all nurses including practical nurses and students. New graduates shall not be required to present the ANA membership card until the year following the year of graduation.

*Selection and purchase of new books*: The Library Committee shall authorize the ordering of new books by the librarian who will have the bills sent to the Nurses' Association, Territory of Hawaii, Inc. for payment. The amount of purchase of such shall fall within the amount granted by the Margaret Jones Memorial Fund.

Books, pamphlets and periodicals for purchase shall be selected according to the following criteria:

1. Emphasis shall be placed on the needs of the graduate nurse since student nurses have access to nursing school libraries.
2. There shall be broad distribution of areas of content with nursing subjects.
3. Material intended for lay reading shall not be included.
4. Care shall be taken to avoid duplication of that which is readily available elsewhere.
5. Pamphlets shall be increased and adequately filed since the most up-to-date and practical material is available in pamphlet form.

Suggestions for books to be purchased shall be solicited from representative nursing groups.

*Renewal of periodicals*: Subscriptions to current periodicals shall routinely be renewed annually by the librarian to be paid from the Margaret Jones Memorial Fund except when otherwise recommended by the Library Committee.

*Listing and review of new books*: At least two books newly available in the library shall be selected for review by persons approved by the Library Committee for publication in each issue of the INTER-ISLAND NURSES' BULLETIN whenever possible. The review will appear over the reviewer's name but the book will be returned to the library. The Library Committee will be responsible for procedure of obtaining and presenting reviews to the BULLETIN editor.

The Library Committee will send out requests annually for catalogues of universities offering courses for graduate nurses. These will be filed as accessibly as possible in the library.

*Library Committee—Functions*: To determine library needs of nurses, select and recommend purchase of pertinent books and periodicals, assist librarian in making such materials accessible, obtain reviews for INTER-ISLAND NURSES' BULLETIN and list new books as they become available in the library.

*Library Committee—Membership*: At least one member of the Library Committee shall be held over from the previous year.

*Library Governing Committee*: The chairman of the Library Committee shall represent the association on this committee.

**Keep For Future Reference**

# BY-LAWS
# of
# NURSES' ASSOCIATION, TERRITORY OF HAWAII, INC.

*(As Revised—October 29, 1952)*

ARTICLE I—Title and Functions

Section 1. The name of this association shall be the Nurses' Association, Territory of Hawaii, Inc.

Section 2. The functions of the Nurses' Association, Territory of of Hawaii, Inc. shall include the following:

1. To assist with the definition of the functions of nurses and to promote standards of professional nurse practice.
2. To assist with the definition of the qualifications for the practitioners of nursing including those in the various nursing specialties.
3. To promote legislation and to speak for nurses in regard to legislative action concerning general health and welfare programs.
4. To promote and assist with periodic surveys of territorial nursing resources.
5. To promote and protect the economic and general welfare of nurses.
6. To provide professional counseling service to

individual nurses, and to their employers in regard to employment opportunities and available personnel.

7. To cooperate with the Hawaii League for Nursing in activities which concern both organizations.
8. To represent nurses and serve as their territorial spokesman with allied professional and government groups and with the public.

ARTICLE II—District Associations

Section 1. District nurses' associations which have been or hereafter may be organized, whose constitution and by-laws are in harmony with the by-laws of this association and have been approved by majority vote of the board of directors of this association, shall be recognized as constituent associations of the Nurses' Association, Territory of Hawaii, Inc.

Section 2. The boundaries of the district nurses' associations shall be clearly defined and recorded by the board of directors of this association. The boundaries may be changed by two-thirds vote of the board of directors of this association provided such change has been approved by each district involved.

Section 3. Any district nurses' association which fails to comply with the requirements of these by-laws, or for other causes deemed sufficient, may be disqualified as a constituent association of the Nurses' Association, Territory of Hawaii by two-thirds vote of the board of directors provided due notice has been given to the district association three months before the vote is taken.

Section 4. A district nurses' association which has been disqualified may be reinstated by two-thirds vote of the board of directors of this association.

ARTICLE III—Membership

Section 1. The membership of the Nurses' Association, Territory of Hawaii, Inc. shall consist of active and associate membership of the constituent district associations.

The presentation to this association of a classified list of active and associate members in good standing in the district nurses' associations, signed by the secretary of those associations together with the annual dues of such members, shall establish such members of the district nurses' associations as members of this association.

Members of district nurses' associations shall be registered nurses, graduates of a state or territory accredited school of nursing offering programs of not less than two years of instruction and clinical practice in hospitals and in other community agencies. The preparation for women nurses must include instruction and practice in medical and surgical nursing of men and women and in obstetric and pediatric nursing. The preparation for men nurses must include instruction and practice in the care of men in medical, surgical and urological nursing.

Section 2. The active members of this association shall be the active members of the constituent district nurses' associations and shall have all privileges of membership. Only active members shall have the privileges of voting and serving as delegates or alternates at conventions and special meetings of this association and of the American Nurses' Association. Only active members will have representation in the International Council of Nurses. Only active members shall be eligible to hold office and to serve as chairmen of standing committees of this association.

Section 3. The associate members of this association shall be the associate members of the constituent district nurses' associations provided that such membership shall not be denied to any eligible nurse unless such nurse anticipates employment for more than thirty (30) days during the current calendar year. No member or applicant for membership shall be required to become an associate member if active membership is preferred. The associate member shall be an associate member of the American Nurses' Association.

Section 4. Honorary recognition may be conferred by a unanimous vote at any annual convention on persons other than registered professional nurses who have rendered distinguished service or valuable assistance to the nursing profession upon recommendation of the board of directors. Honorary recognition shall not be conferred on more than two persons at any annual convention.

Honorary recognition does not confer the privilege of voting nor require payment of dues. These persons may attend the meetings of the assembly only on invitation. They will receive the official publications and bulletin of the Nurses' Association, Territory of Hawaii, Inc.

Section 5. A member who changes her residence from the state in which she is a member of the state nurses' association through which she is a member of the American Nurses' Association shall be eligible to membership in the Nurses' Association, Territory of Hawaii, Inc. for the remainder of the fiscal year without further payment of dues, provided she meets the requirements for membership in this association and the request for transfer of membership is accepted by this association. Such request shall be sent to the secretary of this association by the secretary of the state nurses' association issuing the transfer.

A member of this association who moves out of this territory should apply to the secretary of her district association for transfer of her membership to the state nurses' association of the state in which she will reside.

ARTICLE IV—Officers

Section 1. The officers of this association shall be a president, a first vice president, a second vice president, a secretary, a treasurer and six (6) directors.

Section 2. Officers shall be elected at annual conventions as hereinafter provided.

Section 3. Officers shall perform the duties usually performed by such officers and also such duties as are specified by these by-laws and designated by the board of directors of this association.

Section 4. Vacancies in office shall be filled as hereinafter provided.

Section 5. No officers shall be elected to the same office for more than two (2) successive terms.

ARTICLE V—Elections

Section 1. The president, the second vice president and the treasurer shall be elected at the annual conventions held in the even years; and the first vice president and the secretary shall be elected at the annual conventions held in the odd years.

The term of office of these officers shall commence at the adjournment of the annual convention at which they are elected and shall continue for two (2) years or until their successors are elected.

Section 2. At each annual convention two (2) directors shall be elected to serve for three (3) years or until their successors are elected.

Section 3. All elections shall be by secret written ballot. A ticket of at least two (2) candidates for each office shall be prepared and presented to the convention assembled by the Committee on Nominations. No name shall be presented to the convention unless the nominee has agreed to serve if elected.

Section 4. A plurality vote of those present, entitled to vote and voting, shall constitute an election.

Section 5. On the first day of the annual convention the president shall appoint a special committee of tellers who shall act also as inspectors of the election. There will be one teller from each district nurses' association. No nominee or candidate for any office shall be appointed a member of this committee.

Section 6. The secretary of this association shall furnish the tellers at least two (2) hours before the opening of the polls a complete list of delegates and alternates of district nurses' associations entitled to vote. The teller in charge of the list of delegates shall check the names of those voting.

Section 7. The teller in charge of the ballot box shall place her official mark upon the back of each ballot. The voters shall then place the ballot in the ballot box.

Section 8. Polls shall be open for such periods of time as specified by the board of directors and noted in the program of the annual convention.

Section 9. Additional nominations may be made from the floor of the convention with the consent of those being nominated.

ARTICLE VI—Duties of Officers

Section 1. The president shall preside at all meetings of this association and all meetings of the board of directors and be a member ex-officio of all committees except the Committee on Nominations. The president or her alternate shall serve as a representative of the association at meetings of the Advisory Council of the American Nurses' Association. In the even years the president shall serve as chairman of the Coordinating Council of the Nurses' Association, Territory of Hawaii, Inc. and the Hawaii League for Nursing. The president shall be empowered to appoint all standing and special committees of this association with the approval of the board of directors.

Section 2. The vice presidents in order of rank shall assume the duties of the president in her absence. In the event of a vacancy occurring in the office of the president, the first vice president shall assume the duties of the president until the next annual convention or until her successor is elected. In the event of a vacancy occurring in the office of the first vice president, the second vice president shall assume the duties of the first vice president until the next annual convention or until her successor is elected. The first vice president shall be a member ex-officio of the Committee on Constitution and By-Laws.

Section 3. The duties of the second vice president shall be the same as those of the first vice president and she shall serve as temporary parliamentarian in the absence of the first vice president. She shall be a member ex-officio of the Committee on Nursing Information and Membership.

Section 4. The secretary shall be responsible for the minutes of the meetings of this association, the board of directors and the Advisory Council. She shall be the custodian of the seal of this corporation and the permanent files of same. She shall be a member ex-officio of the Committee on Nominations. She shall prepare and deliver to the annual convention of this association a report on the accomplishments of this association during the preceding calendar year. She shall deliver to her successor within one month after her election to office all records and the seal of this association. She shall notify all officers, directors and committees of election or appointment; send notices of the time and place of all meetings; send to the secretary of the American Nurses' Association the names and addresses of all officers of the Nurses' Association, Territory of Hawaii, Inc. immediately after their election; and conduct the general correspondence of the association and the board of directors.

She shall keep a correct list of the names and addresses of all members of this association.

The executive secretary shall assume such duties in connection with the work of the secretary as shall be designated by the board of directors.

Section 5. The treasurer shall receive and have charge of all funds of the association, deposit such funds in a bank designated by the board of directors and pay such bills only as shall have been approved by the president.

She shall report to the board of directors the financial standing of the association at each annual convention.

She shall keep an itemized account of all receipts and disbursements and give a written report at meetings of the board of directors and of the association.

She shall give bond subject to the approval of the board of directors for the faithful performance of her duties, and shall submit all books of account for audit as specified by the board of directors.

She shall pay dues to the American Nurses' Association and send notice to district associations as specified in Article XI of these by-laws.

The treasurer shall be a member of the Committee on Finance.

The retiring treasurer shall deliver to her successor within one (1) month after her election to office all money, vouchers, books and papers of the association in her custody with a supplementary report covering all transactions from the date of last audit to the date of surrendering her accounts to her successor.

The executive secretary shall assume such duties in connection with the work of the treasurer as shall be designated by the board of directors.

Section 6. All officers except the secretary and treasurer upon expiration of their term of office shall surrender all property of this association in their possession pertaining to their respective offices to the newly elected president.

Section 7. In addition to the duties of the officers set forth herein, the officers shall have such other duties as implied by their titles.

ARTICLE VII—Board of Directors

Section 1. The members of the board of directors of this association shall be eleven (11) composed of: the president, first vice president, second vice president, secretary and treasurer, and six (6) directors, four (4) of whom shall be selected, one each from the respective districts, to serve as the official representative of that district.

Section 2. The regular meeting of the board of directors shall be held immediately preceding and immediately following each annual convention * at the place where the annual convention is held. The regular

* Except where government regulations or conditions incident upon war may render this impossible.

meetings of the board may also be held at such time and place as shall from time to time be determined by action of the board.

Section 3. Special meetings of the board of directors may be called by the president of this association upon seven (7) days notice to each member of the Board either personally or by mail or by telegraph and shall be called by the president in like manner or by like notice upon the written request of five (5) members of the board of directors. Special meetings shall be held at such time and such place as may be specified in the notice thereof.

Section 4. In the intervals between regular meetings of the board of directors, the president of the association may refer and submit by mail or telegraph to the members of the board of directors definite questions relating to the affairs of the association which, in the opinion of the president, require immediate action on the part of the board of directors. The result of such a referendum which requires a majority vote of the personnel of the board of directors shall control the action of the association, its board of directors, officers, sections, committees, agents and employees.

ARTICLE VIII—Duties of the Board of Directors

Section 1. The board of directors shall:

(a) Transact the general business of the association in the interim between annual conventions.

(b) Establish major administrative policies governing the affairs of the association and devise and mature measures for the association's growth and development.

(c) Provide for the maintenance of territorial headquarters and for making such office the center of activities of the association, including such work of the officers and committees as may be deemed expedient; provide for the proper care of materials, equipment and funds of the association, for the payment of legitimate expenses and for the annual auditing of all books of account by our agent if agency agreement is in effect; otherwise audit shall be made by a certified public accounting firm.

(d) Report to the association assembled at each annual convention through the secretary of this association the business transacted by the board during the preceding year.

(e) Assume responsibility with regard to constituent district nurses' associations as specified in Article II of these by-laws.

(f) Appoint an executive secretary and other personnel, define their duties and fix their compensation.

(g) Create special committees as the need for them arises, dissolving said committees upon the accomplishment of their missions.

(h) Approve the appointment of all members to standing and special committees made by the president in accordance with these by-laws.

(i) Have power to fill any vacancies on the board of directors except a vacancy occurring in the office of the president or first vice president.

(j) Decide upon the exact date and place for holding the annual convention and provide for the payment for a place of meeting when necessary; decide upon the time and place for meetings of the advisory council; hold meetings of the board of directors as hereinbefore provided.

(k) Provide for the establishment and dissolution of sections in accordance with these by-laws.

(l) Verify referendum votes of the board of directors.

(m) Appoint the association's representatives on Board of Management of the Mabel Smyth Memorial Building Committee in the manner provided for by the agreement made on October 15, 1939 between the Nurses' Association, Territory of Hawaii, Inc., the Hawaii Medical Association and The Queen's Hospital.

(n) Recommend to the Governor of the Territory the names of persons suitable for appointments to the Board for the Licensing of Nurses when vacancies on said board occur.

(o) Shall have the right and authority by unanimous vote to appeal to the membership of this association, when necessary, for supplemental finances to carry on the program of the association.

(p) Appoint an active member, in addition to the president, or her alternate, to represent this association at meetings of the Advisory Council of the American Nurses' Association.

(q) Have the power to employ legal counsel and such other paid personnel as may from time to time be needed at fees made known to the board of directors in advance of such employment.

Section 2. No individual member of the board of directors shall pledge any property of this association for security either for a personal or an association loan nor will members contract any liabilities in the name of the association without first having in their possession written permission from the treasurer of this association as approved by the board of directors.

Section 3. There shall be an executive committee, called the sub-NATH, of the board of directors composed of the president, the officers and board members located on the Island of Oahu, and one other island director to be selected in rotation. This committee shall have all the powers of the board of directors to transact business of an essential nature between board meetings. All transactions of this committee shall be verified at the next regularly scheduled meeting of the board of directors.

ARTICLE IX—Advisory Council

Section 1. The board of directors of this association, the past presidents of this association, the presidents of each district association, the chairmen of standing committees, representatives of the Hawaii League for Nursing and the Board for the Licensing of Nurses, shall constitute an Advisory Council to consider and promote the interests of the Nurses' Association, Territory of Hawaii, Inc., provided, however, that no person shall be a member of the Advisory Council who is not a member of the Nurses' Association, Territory of Hawaii, Inc.

Section 2. Meetings of the Advisory Council shall be held immediately preceding and following the annual convention of this association at such time and place as shall be designated in the program of said convention. The Advisory Council shall meet at such other times and places as may be determined by the board of directors.

Section 3. The president of this association shall be Chairman of the Advisory Council.

ARTICLE X—Standing Committees

Section 1. The following standing committees shall be appointed at or immediately after each annual convention to serve until the next annual convention or until their respective successors are appointed:

1. Committee on Finance
2. Committee on Program
3. Committee on Arrangements
4. Committee on Legislation
5. Committee on Constitution and By-Laws
6. Committee on Nominations
7. Committee on Membership
8. Committee on Nursing Information
9. Committee on Margaret Jones Memorial Fund

Section 2. Standing committees except the Committee on Nominations and the Executive Committee (SubNATH) may be composed of both active and associate members of the association and shall assume such duties as are specified in these by-laws and such other duties as may be assigned by the board of directors. Only active members shall be chairmen of standing committees.

Section 3. The Committee on Finance shall consist of at least five (5) members and not more than ten (10), one of whom shall be the chairman as appointed by the president with the approval of the board of directors. The treasurer of the Nurses' Association, Territory of Hawaii, Inc. shall be a member of said committee. This committee shall prepare a budget for the year, advise as to expenditure of funds and report the same to the board of directors at meetings of that body.

Section 4. The Committee on Program shall consist of at least three (3) members representing at least the three major fields of nursing. This committee shall prepare a program for all meetings of this association, subject to the approval of the board of directors. This committee shall act in an advisory capacity to Committees on Program of district nurses' associations throughout the year.

Section 5. The Committee on Arrangements shall consist of at least three (3) members. This committee shall work in conjunction with the Committee on Program, subject to the approval of the board of directors, and shall make local arrangements for the annual convention and perform such other duties as shall be designated by the board of directors.

Section 6. The Committee on Legislation shall consist of at least five (5) members. The membership of this committee shall be representative of all major branches of nursing and various geographic sections of the territory. This committee shall assume such duties as shall be assigned to it by the board of directors.

Section 7. The Committee on Constitution and By-Laws shall consist of at least three (3) members. This committee shall receive all proposed amendments to the by-laws of this association. It shall be responsible for securing an opinion from the American Nurses' Association Committee on Constitution and By-Laws with regard to the same, and shall recommend proposed action thereon to the board of directors of this association. Such proposed amendments shall be submitted for action to the voting body at the annual convention of the association in accordance with the provisions for amendments in these by-laws. This committee shall review the constitution and by-laws of any district nurses' association wishing to become a constituent association of the Nurses' Association, Territory of Hawaii, Inc. The committee shall report its findings to the board of directors of this association, whose decision as to the acceptability of the district shall be final. This committee shall advise district nurses' associations concerning proposed amendments to their constitution and by-laws in order that these may be kept in harmony with the by-laws of this association and of the American Nurses' Association. The first vice president shall be a member ex-officio of this committee.

Section 8. The Committee on Membership shall consist of three (3) or more members representative of various geographic areas of the territory. This committee shall cooperate with the ANA Committee on Promotion of American Nurses' Association Membership, and shall devise ways and means of cooperation with the district nurses' associations in securing members and in methods of organization for making such membership effective. Such action shall be subject to the approval of the board of directors. The second vice president shall be a member ex-officio of this committee.

Section 9. The Committee on Nominations shall consist of not less than three (3) active members. Not more than one (1) member of this committee is to be a member of any one district nurses' association. Ninety (90) days prior to the annual meeting the Committee on Nominations shall send to the district nurses' associations the names of officers then serving, and those whose terms of office will expire at the next annual convention, and shall request from each district nurses' association a list of names of members qualified to fill vacancies in office and willing to serve if elected. These members should be representative of various fields of nursing service. Such lists shall be signed by the president or secretary of the respective district nurses' associations and shall be submitted by the district nurses' associations to the Committee on Nominations of this association sixty (60) days prior to the annual convention. From these lists the Committee on Nominations shall prepare a ticket consisting of at least two (2) nominees for each office to be filled. This ticket shall include representatives of major branches of nursing and various geographic sections of the territory. The secretary shall be a member ex-officio of this committee.

Section 10. The Committee on Nursing Information shall be representative of the various nursing groups in the territory. It shall be the function of this committee to plan and promote the territorial nursing information program subject to the approval of the board of directors. The committee shall inform nurses about the activities of the professional nursing organizations so that they will support the organizations, benefit by their services and participate intelligently in their programs. Also, the committee shall promote better understanding of professional nursing by the public so that it will make discriminating use of professional nursing service and insist on sound preparation for nursing. The second vice president shall be a member ex-officio of this committee.

Section 11. The Committee on Margaret Jones Memorial Fund shall consist of at least three (3) members.

ARTICLE XI—Dues

Section 1. (a) The annual dues to the Nurses' Association, Territory of Hawaii, Inc. shall be eighteen dollars ($18.00) per capita for active members, payable on or before February 10 by the constituent district associations which includes five dollars ($5.00) per capita dues to the American Nurses' Association.

(b) The annual dues for associate members of the Nurses' Association, Territory of Hawaii, Inc. shall be two dollars and seventy-five cents ($2.75) per capita payable on or before February 10 by the constituent district associations, which includes one dollar and twenty-five cents ($1.25) per capita dues to the American Nurses' Association.

Dues for associate members who become active members during any fiscal year and who have paid dues as associate members for that year, shall be fifteen dollars and twenty-five cents ($15.25) in addition to the two dollars and seventy-five cents ($2.75) previously paid. From the amount fifteen dollars and twenty-five cents ($15.25) paid in, three dollars and seventy-five cents ($3.75) will be sent to American Nurses' Association.

(c) The dues for nurses who graduate and are licensed to practice professional nursing after July 1 of any year and become active members of the Nurses' Association, Territory of Hawaii, Inc. shall be eight dollars and fifty cents ($8.50) per capita, for that same year, and payable by the constituent district nurses' association which includes two dollars and fifty cents ($2.50) per capita dues to the American Nurses' Association.

Section 2. Dues received by the district nurses' associations after the 10th of February shall be paid to this association monthly during the remainder of the fiscal year.

Section 3. The district nurses' associations which have not paid dues for any members of this association by March 15 shall be notified by the treasurer and those who have not paid dues by April 15 shall be disqualified as constituent district associations of the Nurses' Association, Territory of Hawaii, Inc.

Section 4. Not later than March 15 the treasurer of this association shall pay to the American Nurses' Association five dollars ($5.00) per capita for the active membership and one dollar and twenty-five cents ($1.25) per capita for the associate membership of the Nurses' Association, Territory of Hawaii, Inc. for the current calendar year.

Section 5. Dues received by this association after February 10 shall be paid to the American Nurses' Association monthly for the remainder of the year.

Section 6. All dues paid to the American Nurses' Association shall be accompanied by a classified list of the members for whom dues are paid.

## ARTICLE XII—Meetings

Section 1. This association shall hold an annual meeting known as the Annual Convention of the Nurses' Association, Territory of Hawaii, Inc. at such time and place as shall be determined by the board of directors.

Section 2. The order of business of each annual convention of this association shall be in accordance with the program adopted at the beginning of the convention and shall include:

a. Call to order
b. Invocation
c. Appointment of tellers
d. President's address
e. Roll call of delegates
f. Report of Program Committee
g. Reading of minutes
h. Reports of officers
i. Reports of sections
j. Reports of district nurses' associations
k. Reports of standing committees
l. Reports of special committees
m. Old business
n. New business
o. Election of officers
p. Adjournment

Section 3. Special meetings of this association may be called by the board of directors and shall be called by the president upon written request of a majority of the district associations.

Section 4. Notice of all meetings of this association shall be sent to the president and the secretary of each district association and to all members of this association prior to the meeting in question. Notices of the annual convention shall be mailed at least one (1) month before the first day of the convention and notices of special meetings shall be mailed at least ten (10) days before the first day of the meeting.

## ARTICLE XIII—Sections

Section 1. (a) Sections may be established by a majority vote of the board of directors of this association.

(b) A section may be established for each of the following groups of professional nurses:

(1) Private duty nurses
(2) General duty nurses
(3) Public health nurses
(4) Institutional nursing service administrators
(5) Educational administrators, consultants, and teachers
(6) Industrial nurses
(7) Special groups

(c) Members of an occupational group in the territory shall be eligible to apply for status as a section when they meet the following criteria:

(1) In the Nurses' Association, Territory of Hawaii, Inc. with a membership of less than 1500, if they number at least thirty-five (35); and
(2) If the members of the occupational group desiring status as a section have functioned as a conference group within one of the established sections for a year; and
(3) If they have demonstrated group interest; and
(4) If they have developed a program; and
(5) If the needs of such a group cannot be met in any existing section or by continuation as a conference group.

(d) Membership in the Special Groups Section of the Nurses' Association, Territory of Hawaii, Inc. shall be open only to those nurses who are not eligible for membership in any other section.

Section 2. Functions of sections may include the following:

(a) Define the qualifications for membership which are consistent with the general membership requirements of the Nurses' Association, Territory of Hawaii, Inc.

(b) Make rules for its government, provided these shall in no way conflict with the by-laws of the Nurses' Association, Territory of Hawaii, Inc. and shall be approved by the board of directors.

(c) Define the functions, standards, and qualifications for practice within the occupational field, these to be developed for each special field by the practitioners within it.

(d) Initiate studies or experiments for the improvement of practice within the field in relation to the overall purpose of the Nurses' Association, Territory of Hawaii, Inc.

(e) Study the general welfare and economic needs of the members and develop desirable standards of employment.

(f) Promote the organization of subunits within the section in order that groups which have like interests shall have the opportunity of meeting to consider the economic security program separately from other groups in the same section whose economic interests might be somewhat different. The subunits shall have the privilege of reporting directly to the board of directors of the Nurses' Association, Territory of Hawaii, Inc.

(g) Represent the occupational interests in district, territorial, and national meetings.

(h) Develop relationships with allied professional groups for conferences or committee work related to the objectives of the Nurses' Association, Territory of Hawaii, Inc.

(i) Conduct programs of special interest to the members of the occupational group or participate with other sections that have similar interests.

(j) Organize conference groups on request for special interests within the section.

(k) Develop and actively promote a program for intergroup relations within the section.

(l) Plan a program of work and prepare an appropriate budget annually for presentation to the Nurses' Association, Territory of Hawaii, Inc. Finance Committee.

(m) Make pronouncements in its own name, provided they are not in opposition to the policies accepted by the House of Delegates and do not purport to represent the policies of the association as a whole.

(n) Interpret all policies accepted by the House of Delegates that affect the section and publish same in its own name.

(o) Keep open direct channels of communication between the Nurses' Association, Territory of Hawaii, Inc. and district sections, with information going simultaneously to the executive secretary of the Nurses' Association, Territory of Hawaii, Inc. and the presidents and the secretaries of the district nurses' associations.

Section 3. Officers of the section shall be chairman, vice chairman and a secretary. The officers shall be elected annually at the annual convention of this association. The newly elected secretary will forward immediately to the secretary of this association the names and addresses of all newly elected officers.

Section 4. A section may be dissolved by two-thirds vote of the board of directors upon the following conditions:

> Upon the recommendation of the section concerned, or upon agreement by the board of directors and the section that there is no reason for its continuance, or upon the section's failure to carry out its objective or to conform with the requirements or principles of this association.

Section 5. A section which has been dissolved by action of the board of directors of this association in which the section does not concur, may appeal to said board of directors for reconsideration, or may appeal to this Association at any annual convention. The decision of this Association shall be final.

Section 6. All members of a section in attendance at a section meeting are entitled to vote on all matters coming before the section.

Section 7. Sections may engage in fund-raising, provided however, that plans for fund-raising be submitted to and approved by the board of directors.

### ARTICLE XIV—Representation

Section 1. The voting body at all meetings of this association shall consist of the accredited delegates in attendance from the district nurses' associations.

Section 2. Each district nurses' association shall be entitled to one delegate for each ten (10) active members, or portion thereof, computed on the basis of membership thirty (30) days prior to the opening day of the annual convention of the Nurses' Association, Territory of Hawii, Inc. Any district nurses' association having less than ten (10) active members shall be entitled to one delegate. (Care should be taken in the district associations to choose delegates from the various fields of nursing.)

Section 3. The secretary of each district nurses' association shall send a list of accredited delegates from that association by the most expeditious means, to the secretary of the Nurses' Association, Territory of Hawaii, Inc., at least thirty (30) days before the opening of the convention. A list of alternates will also be submitted by each district nurses' association in conjunction with the list of accredited delegates.

Section 4. If all the accredited delegates from the district nurses' association are not in attendance at the convention, the president of the district nurses' association, or her empowered representative, may fill the vacancies from the list of alternates for that association. If the list of alternates is exhausted and vacancies remain, the president of the district association, or her empowered representative, shall be empowered to appoint as delegates other members of that association who are in attendance.

Section 5. All delegates shall present credentials at the time of registration.

Section 6. Each accredited delegate shall be permitted to cast not more than one (1) vote in any election or any matter coming before the convention. This provision applies also to alternates or members who are acting as delegates appointed to represent a district nurses' association.

Section 7. (a) The Nurses' Association, Territory of Hawaii, Inc. is entitled to representation at biennial conventions or special meetings of the American Nurses' Association on the basis of one (1) delegate for every two hundred (200) active members of each section or fraction thereof, such delegate or delegates to be elected in a manner to be determined by the section. Each section, through the Nurses' Association, Territory of Hawaii, Inc., shall certify the names and addresses of the delegate or delegates and their respective alternates elected for such section. The number of delegates to be computed on the number of active members of each section of the Nurses' Association, Territory of Hawaii, Inc. in good standing in the ANA on December 31 of the year preceding a biennial convention or special meeting. Each section of each district nurses' association shall be asked to submit to the secretary of the corresponding territorial section a list of nominees for delegates and alternates to the biennial convention or special meeting. The number of delegates to be nominated by each section of the district shall be determined on the basis of membership as stated above. If any district nurses' associa-

tion has no sections, it may submit names from the various fields of nursing within the district on the basis of membership as stated above. If such a district has less than one hundred (100) members, it may submit the name of one (1) nominee for delegate.

(b) Since the Nurses' Association, Territory of Hawaii, Inc. is entitled to three (3) delegates-at-large to biennial conventions or special meetings of the American Nurses' Association, these delegates-at-large shall be selected by the NATH board of directors from names submitted by the districts.

Section 8. If a special meeting is held in the month of January or February, for the purpose of computing the number of delegates to which any section of the Nurses' Association, Territory of Hawaii, Inc. shall be entitled, the number of active members shall be deemed to be the active members in good standing as active members of the American Nurses' Association on November 1 of the year preceding a special meeting, as evidenced by dues paid to this association or postmarked by such time.

Section 9. The representatives of this association at meetings of the Advisory Council of the American Nurses' Association shall be two (2) active members of this association, one (1) of whom shall be the president of this association or her alternate.

### ARTICLE XV—Coordinating Council

Section 1. Membership. There shall be a Coordinating Council which shall be composed of all the officers and other members of the board of directors of Nurses' Association, Territory of Hawaii, Inc. and all of the officers and other members of the board of directors of the Hawaii League for Nursing.

Section 2. Officers. Starting with the president of the Nurses' Association, Territory of Hawaii, Inc., the president of that association and the president of the Hawaii League for Nursing shall serve alternately for one (1) year as chairman of the Coordinating Council.

Section 3. Purpose and Functions. The coordinating Council shall promote the coordination of those programs that are of common concern to the Hawaii League for Nursing and the Nurses' Association, Territory of Hawaii, Inc. To promote such coordination, the Coordinating Council shall:

(a) Serve as a forum for the discussion of different points of view for the purpose of reaching agreement when feasible;

(b) Plan together, serve as a clearing house for activities of common concern to both the Hawaii League for Nursing and the Nurses' Association, Territory of Hawaii, Inc., and agree on allocation of new major programs; and

(c) Consider priorities for and timing of interrelated activities of the Hawaii League for Nursing and the Nurses' Association, Territory of Hawaii, Inc.

The Coordinating Council shall also act as sponsors of and advisers to the state student nurses council or organization.

Section 4. Steering Committee. There shall be a Steering Committee for the Coordinating Council which shall be authorized to make recommendations when, because of an emergency or other special situation, a recommendation must be made before the Coordinating Council can meet. The Steering Committee for the Coordinating Council shall be composed of the president and elected secretary of the Nurses' Association, Territory of Hawaii, Inc. and the president and elected secretary of the Hawaii League for Nursing.

Section 5. Special Committees. The Coordinating Council of the Nurses' Association, Territory of Hawaii, Inc. and the Hawaii League for Nursing shall have authority to appoint special committees, if necessary.

### ARTICLE XVI—Quorum

Section 1. Five (5) members of the board of directors, one (1) of whom shall be the president or a vice president, and representatives from a majority of the constituent district nurses' associations, shall constitute a quorum for the transaction of business at any annual convention or special meeting of the Nurses' Association, Territory of Hawaii, Inc.:

Section 2. Five (5) members of the board of directors, one (1) of whom shall be the president or a vice president, shall constitute a quorum at any meeting of the board of directors.

Section 3. A majority of members of the Advisory Council shall constitute a quorum of the Council.

Section 4. A majority of members of any standing or special committee shall constitute a quorum.

### ARTICLE XVII—Duties of District Nurses' Association

Section 1. It shall be the duty of each constituent district nurses' association of the Nurses' Association, Territory of Hawaii, Inc.:

(a) To require that all of its members have the qualifications enumerated in Article III, Section 1, of these by-laws.

(b) To send to the secretary of this association the names and addresses of all officers of the district nurses' association immediately following their election or appointment.

(c) To confer with the Committee on Constitution and By-Laws of this association before adopting any proposed amendments to its constitution and by-laws.

(d) To send to the secretary of this association a copy of the constitution and by-laws and all amendments adopted by the district nurses' association.

(e) To pay dues to this association as provided in Article XI, Sections 1 and 2, of these by-laws. Such dues shall be sent to the treasurer of this association with typewritten classified lists in duplicate of the members for whom dues are paid.

(f) To send to the secretary of this association the names and addresses of all those who are entitled to attend the annual convention as members of the voting body at least thirty (30) days before the opening day of the convention and to inform the secretary of all changes as promptly as possible.

(g) To nominate delegates to the biennial convention and special meetings of the American Nurses' Association in conformity with Article XIV, Sections 6 and 7, of these by-laws and to send the names of those nominees, with addresses, to the secretary of this association.

(h) To report to this association as may be required by the board of directors in order to comply with the constitution and by-laws of the Nurses' Association, Territory of Hawaii, Inc.

### ARTICLE XVIII—Fiscal Year

The fiscal year for this association shall be the calendar year.

### ARTICLE XIX—Official Organs

The American Journal of Nursing and the Inter-Island Nurses' Bulletin shall be the official organs of this association.

### ARTICLE XX—Parliamentary Authority

The rules contained in *Robert's Rules of Order Revised* shall govern all meetings of the board of directors, committees, special meetings and conventions of this association in all cases wherein they are applicable and not inconsistent with these by-laws.

### ARTICLE XXI—Amendments

Section 1. These by-laws may be amended at any annual convention of this association by two-thirds vote of the accredited delegates present and voting. All proposed amendments shall be in possession of the secretary of this association at least thirty (30) days before the date of the annual convention and shall be appended to the call for the meeting.

Section 2. These by-laws may be amended at any annual convention by unanimous vote without previous notice.

## NURSES' ASSOCIATION, TERRITORY OF HAWAII, INC.

### OFFICERS

### 1952-1953

| | Elected | Term Exp. |
|---|---|---|
| *President:* Mrs. Elizabeth McCall, Kula Sanatorium, Waiakoa, Maui | 1952 | 1954 |
| *1st Vice President:* Sister Mary Albert, St. Francis Hospital, Honolulu; Ph. 66171 | 1951 | 1953 |
| *2nd Vice President:* Mrs. Margaret Makekau, Lanakila Health Center, Honolulu; Ph. 86481 | 1952 | 1954 |
| *Secretary:* Mrs. Isabel Medeiros, Kuakini Hospital, Honolulu; Ph. 62236 | 1951 | 1953 |
| *Treasurer:* Mr. Lawrence Katsuyama, Kuakini Hospital, Honolulu; Ph. 62236 | 1952 | 1954 |

### DIRECTORS

(Term of office: 3 years—two directors elected each year.)

| | | |
|---|---|---|
| Moira Wilson, 123 Wainaku Avenue, Hilo, Hawaii | 1952 | 1955 |
| Thelma Hensley, Mahelona Hospital, Kealia, Kauai | 1950 | 1953 |
| L. Rose Littel, Puunene Hospital, Puunene, Maui | 1951 | 1954 |
| Mrs. Hazel Richards, 819 Puunani Pl., Honolulu; Ph. 69645 | 1950 | 1953 |
| Mrs. Lois Bell, The Liberty House, Honolulu; Ph. 56921 | 1950 | 1953 |
| Harriet Kuwamoto, Kapahulu Health Center, Honolulu; Ph. 71921 | 1951 | 1954 |
| Mrs. Flora Ozaki, (Oahu), Board of Health, Honolulu; Ph. 50511, Loc. 219 | 1952 | 1955 |

## REPORT OF THE ECONOMIC SECURITY WORKSHOP

LOIS BELL*

Renewed efforts to meet the nation's critical need for more registered nurses by improving working conditions were discussed in the National Economic Security Workshop held in Omaha, Nebraska by the A.N.A. September 25 through September 27, 1952.

Fifty-five representatives from thirty-four states and the Territory of Hawaii were divided into seven discussion groups to discuss ways and means of promoting the socio-economic program on the state level.

The workshop was conducted on the principle that decisions are more easily made by groups of not more than ten or twelve persons. Nurses with divergent viewpoints were grouped together with the idea of letting them get acquainted, talk out their differences and exchange information.

A corps of twenty A.N.A. resource people and consultants was at the disposal of the group at all times.

The group in which I participated, for instance, was composed of one assistant executive secretary from Pennsylvania which has a well established going program, the executive secretary from Indiana which state has voted down the program, the Public Relations Consultant for Illinois State Nurses Assn., the chairman of the Delaware State Economic Security Committee now in the preliminary stages of the program, the president of Nebraska State Nurses Assn., the assistant executive secretary of the Florida State Nurses Assn., which has done an outstanding job of recruiting members by personal contact in order to promote the program, the executive secretary from Virginia whose program has not gained any momentum, the chairman of the Committee on Employment Conditions of Registered Nurses of the A.N.A. who is also the dean of nurses at University of Washington and an outstanding promoter of the program both on the state and national level, and two members of the A.N.A. staff. Do you wonder why I was a listening and asking participant?

After each session, the entire body convened briefly in a large meeting to hear reports on progress of discussions made by each group. These were called "feed-back" sessions. The third morning session closed with a general meeting at which final recommendations from the groups were received and general conclusions formulated.

Nurses discovered that the group plan resulted in more frankness, enabling the nurses to express their fears, uncertainty and lack of knowledge about the economic security program and indicated that this technique is feasible for workshops on a state and district level.

Nurses agreed at the out-set that the professional nurse's first responsibility is to the patient.

This public service duty of the nurse has long been regarded as a reason for nurses not pursuing

* Industrial Nurse, Liberty House.

their rights, as Americans, to a standard of living and working consistent with their professional status.

The Economic Security Program of A.N.A. was developed six years ago to improve these conditions.

A growing number of states are developing collective bargaining techniques, with the state associations serving as spokesmen for nurses in relation to their working conditions.

The public is concerned because economic factors have a direct effect upon:

1. Keeping sufficient numbers of nurses in active service.
2. Attracting inactive nurses back to work.
3. Recruiting qualified entrants to schools of nursing.
4. Stabilizing nursing service in hospitals and other agencies.

The economic security program is urgent now because our country is short 65,000 professional nurses for civilian needs alone; military requirements make the shortage even more alarming. We must increase and conserve nurse power and safeguard the health, morale and efficiency of every nurse.

What does the program ask for nurses?

1. Salary increases to insure equitable living standards and just compensation for professional qualifications and responsibilities.
2. A five day, forty-hour week protected by premium pay for overtime.
3. Pay and promotion based on the job and professional competence regardless of race, color, creed, sex or marital status.
4. Regular length of service and merit pay increase.
5. Paid vacations and sick leave, social security and supplemental retirement plan.
6. Job security through protection against unfair dismissal, favoritism, and discrimination.
7. Elimination of split shifts, unpaid on-call time and arbitrary shift rotation.
8. Premium pay for unpopular shifts to encourage round the clock coverage.

All nursing resources are human resources and nurses need adequate incomes and good working conditions just as all human beings do.

To organize an Economic Security Program, strong, effective *section* organization is necessary. In states with small nurse populations, section organization on a district level may be impractical or impossible, but it is essential on state levels.

Each section's elected committee on section policies is responsible for the preparation of employment standards and for annually reviewing the standards and recommending revisions.

a. The section's committee on section policies presents the tentative standards or recommended revisions to the entire section at its annual meeting.

b. Each provision is discussed, amended if desired, and adopted by the section.

c. The section chairman presents the standards as adopted by the section to the NATH Board of Directors.

d. The NATH Board of Directors reviews the standards and approves them, or it may withhold approval and recommend certain revisions until they are reconsidered by the section and again presented to the NATH Board of Directors. (Board action constitutes endorsement and does not imply the privilege of making changes in the standards directly.)

As soon as the standards are approved by the NATH Board of Directors, they become official standards, approved and recommended by the Nurses Association, Territory of Hawaii.

In order for the Nurses Association to function as exclusive spokesmen for nurses in all questions affecting their employment and economic security, they must be well prepared in advance to do so.

Strong, effective state organization is necessary to the successful implementation of the economic security program which means for us here in Hawaii—

1. Increased membership in NATH as our present budget is unable to cope with the demands of the program.
2. Legal and industrial relations counsel; this may be secured in one person if such a person is to be found.
3. The assistance of a nurse with experience in the program; this may be on a temporary basis until the program is well underway.
4. Full time executive secretary.
5. Possible grants-in-aid from A.N.A. Small state associations such as ours have found it more difficult to promote such a program because of lack of finances and trained personnel. In the Omaha conference, this was repeatedly emphasized and brought to the attention of the A.N.A. which will, in the near future, have something concrete to offer.

All who have succeeded with putting an economic security program on an operating basis agree that it is hard going but worth the challenge.

## BOOK REVIEW

*Health Observation of School Children*—By George M. Wheatley, M.D., M.P.H., and Grace T. Hallock. 436 pp. Price $4.75. McGraw-Hill Book Company, Inc., 1951.

The purpose of this book is to give teachers and others sufficient background to observe and understand the child of school age in health and sickness. How children grow and develop, how healthy bodies and minds work, and how they defend themselves against the strains and stresses of life is presented in a very entertaining style.

The authors draw from the fields of physiology, anatomy, hygiene, sociology, psychology and economics to explain the topics under discussion. The detailed information the teacher will need if she is to develop skill in identifying good health and departures from good health, is presented in numerous charts, diagrams, illustrations and tables. The reader has an opportunity to

evaluate what he has learned in each chapter and receives definite help in the application of the material in the closing sections entitled: Do You Know, Suggested Activities, Selected References.

One feels how importantly the teacher can contribute to a child's safe and happy adjustment by her intelligent use of opportunities to guide him wisely through the stages of normal development and his troubled times. The effectiveness of school health services depend to a considerable extent upon her understanding and skill in observing the child.

The nurse working in the school will find this book a valuable reference in her health counselling of parents and older children.

ALISON MACBRIDE, R.N.

## BAZAAR

FLORA OZAKI*

"Fun and Food for the Whole Family" is the theme of the big money making project of the Nurses Association, District of Oahu.

It will be a BAZAAR on February 6 (Friday, 6-11 p.m.) and February 7 (Saturday, 11 a.m.-11 p.m.). There will be lots of space for many people as it will be held on the Lanai of Mabel Smyth building, the adjoining lawn of Queen's Hospital, and the Queen's classroom.

This bazaar will have numerous enticing booths. They are as follows:

*Clothes* for men, women, boys, girls and tots.
*Plants* to give you many hours of joys, such as: orchids, ti, cactus, anthuriums, etc.
*Food*—tasty saimin and barbecue, hot dog and soft drinks, homemade pies, cake, cookies.
*Concession* for children and family, i.e., fish ponds, darts, baseball throw, hitting milk bottles, etc.
*Handwriting analysis*
*Fortune telling*
*Unusual gifts* (white elephants), books, linen.

General chairman is Mrs. Gladys Leong (tel. 625255). Assisting her as co-chairmen are Mrs. Rosie Kim Chang (bu. 55981, h. 998098) and Miss Lillian Jonsrud (tel. 944262). Committee members are as follows:

*Food*—Mrs. Margaret Wong (bu. 6061, h. 745110)
*Clothing*—Miss Laura Draper (bu. 50511 loc. 230, h. 546654)
*Unusual gifts*—Miss Audrey Booth (bu. 55981) books, linen, white elephant
*Plants*—Mrs. Marie Mau (tel. 77882)
*Fortune Telling*—Mrs. Marjorie Elliot, Mrs. Betty Rodrigues
*Concession*—Mrs. Rosie Kim Chang, husband committee
*Script*—Miss Olga Larsen (bu. 86471, h. 69895)
*Donations*—Mrs. Myrtle Schattenburg (bu. 52349), Mrs. Elaine Johnson (tel. 71981). (Clearance committee for large contributions.)
*Maintenance*—Mr. Lawrence Katsuyama (tel. 62236)
*Student Inter School Council*—Miss Marjorie Hahn, president (Kuakini) (Schools of nursing)
*Finance*—Miss Alice Shida (bu. 55981)
*Publicity*—Mrs. Flora Ozaki

Plan to have your meals with your family at our BAZAAR. There will be *FUN*, *FOOD*, and *BARGAINS* for all!

* Publicity Chairman, Fund Raising Project, Nurses Association, District of Oahu.

## PLATFORM FOR NATH

*Provide health protection for the people of the Territory by*:

1. Active participation with allied groups in meeting health needs of the territory.
2. Cooperation with the civil defense administration in planning health care for times of emergency.
3. Promotion of most effective utilization of nursing time through determination of functions of professional and sub-professional nursing personnel.
4. Promotion of adequate nursing coverage in terms of quantity and quality in all private official institutions and agencies.

*Aid nurses to become strong members of their profession by*:

1. Recognition on the part of nurses that they have responsibility for meeting the emotional, social and spiritual as well as the physical needs of patients.
2. Promotion of legislation to provide nursing scholarships and financial aid for nursing education programs.
3. Support of and participation in plans for greater social security for nurses. This relates to governmental and to private insurance plans.
4. Improvement of working conditions of nurses through increased participation by nurses in their professional organizations. This refers to support of economic security programs, development of personnel policies, study and support of adequate salaries and classification.
5. Maintenance of professional counseling service.

*Promote good health care for peoples of the world through*:

1. Organizational and individual support of the United Nations and particularly of its agency, the World Health Organization.
2. Promotion of better understanding of interpersonal relationships at home and abroad.

## ARMY TO RECALL 500 NURSES

The recall to active military service of 500 reserve Army nurses and 125 reserve women's medical specialists was approved July 31 by Anna M. Rosenberg, Assistant Secretary of Defense for manpower.

Included in the recall of reservists from the Women's Medical Specialist Corps are 70 dieti-

tians, 31 physical therapists and 24 occupational therapists.

The first involuntary recall of women reservists in the medical branches of the Army since early in the Korean campaign is necessary for replacement of women about to be released from active duty. Volunteers among qualified nurses and women medical specialists have been inadequate to meet requirements.

In approving the recall, Mrs. Rosenberg directed that the National Advisory Committee of the Selective Service System, now used in selecting doctors and dentists, screen nurses and women medical specialists to assure that no individual essential to the national health, safety and interest will be obliged to leave her civilian job.

The recall will continue for three months beginning in February 1953. Fifty per cent of those to be ordered to active duty are scheduled for recall the first month, with 25 per cent to be called in each following month. Reservists selected for recall will be given at least 120 days' notice in which to take care of personal business.

The order of recall has been established on the following system:

Group I—All volunteers. Volunteers will be credited to Army area quotas.

Group II—Volunteer and inactive reservists who have received active duty training pay since June 23, 1950.

Group III—Members of the Volunteer Reserves.

Group IV—Members of troop program units of the Organized Reserves.

Selection within these groups will be made in the following order:

1. Unmarried officers with no dependents.
2. Unmarried officers with dependents.
3. Married officers with no dependents.
4. Married officers with dependents.

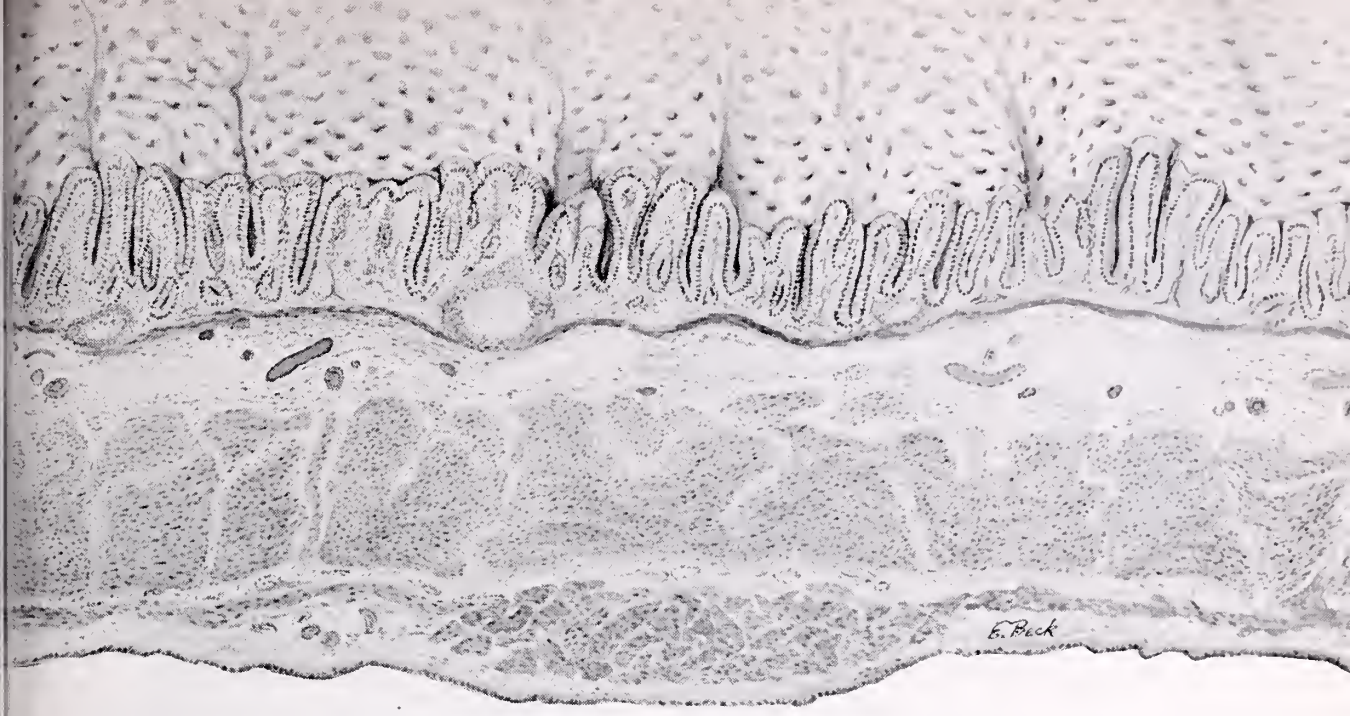
It is further specified that the maximum age-in-grade limitation will be 50 years of age, and that no person will be ordered into active military service under this program without her consent if she has already served involuntarily in active military service subsequent to June 23, 1950.

Quotas for the recall have been established for each of the six continental Army areas based on numbers of Reservists in those areas. Within Army areas, eligible Reserve officers will be nominated for recall within established quotas. Lists of these nominees will be furnished the National Advisory Committee and to the state and local advisory committees, so that each reservist will be considered on the basis of her essentiality to the community.

In determining the selection of individual officers of the ANC, Army commanders will make every effort to enlist the cooperation and assistance of professional organizations.

## CORRECTION:

In the November-December issue the report from our representative on the Board of Management, Mabel Smyth Building should have carried the name of Mrs. Ethel Hensley Brown.




Normal peristaltic action results from activity of the muscle layers as they are gently distended by bulk within the intestine; mucosal irritants cause overactivity of the muscle layers resulting in hyperperistalsis or spasm.

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Abnormally prolonged colonic retention, whether in a spastic or an atonic colon, demands the greatest care to assure correction.

The mucosa does not require stimulating; hence, stimulating cathartics, "roughage" and other physical and chemical irritating measures, are today often considered irrational.

On the other hand, the muscularis does require a stimulus to initiate peristalsis. This physiologic stimulus is the mechanism by which bland distention of the colon establishes a reflex, with the muscularis at the terminus of the reflex arc.

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A program of Metamucil therapy helps to restore proper tone to the intestinal musculature, thereby establishing proper bowel habits.

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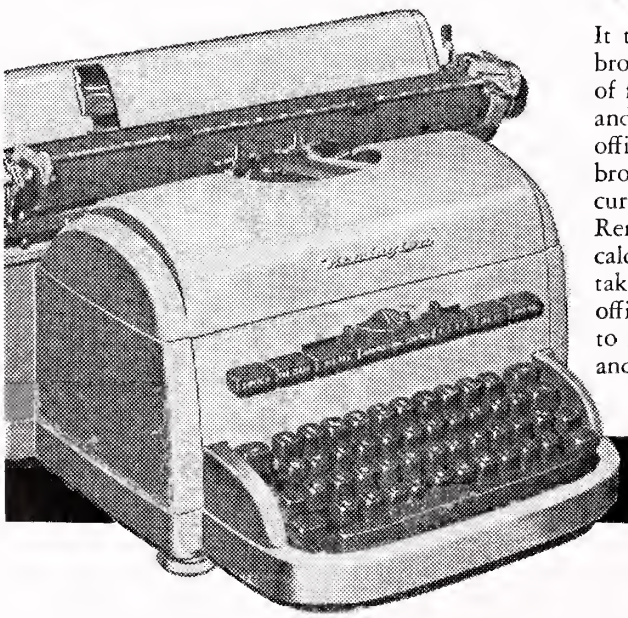
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1. Reich, W. J., et al. (1952), A Recent Advance in Estrogen Therapy. II. Amer. J. Obst. & Gynec., 64:174, July. 2. Reich, W. J., et al. (1951), A Recent Advance in Estrogen Therapy. I. Amer. J. Obst. & Gynec., 62:427, August.

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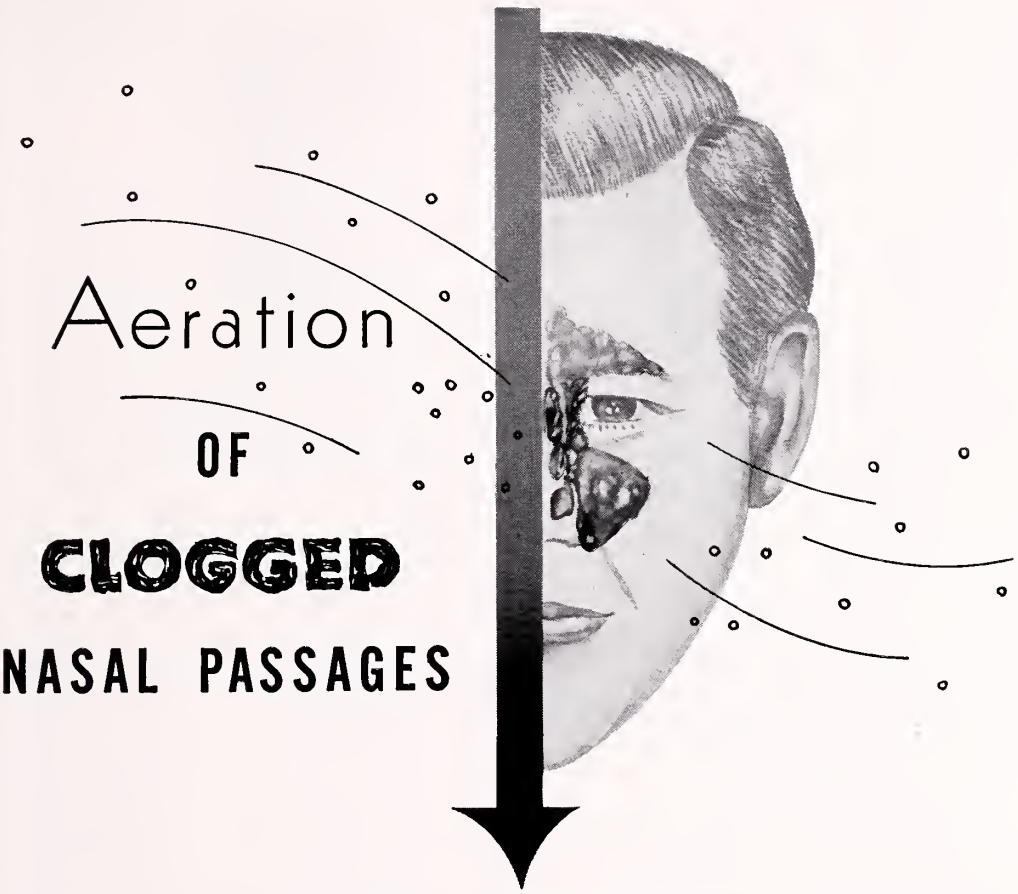


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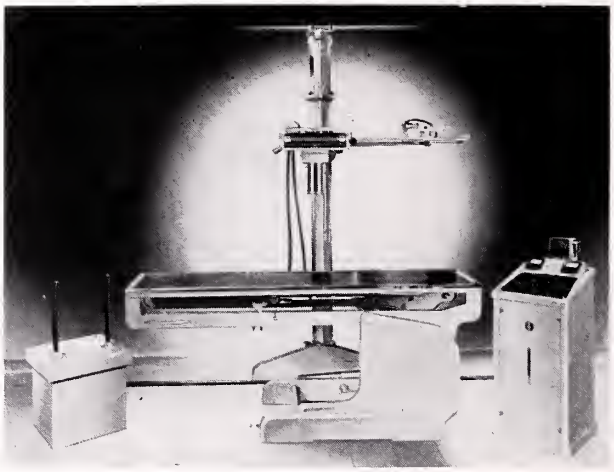
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1. Von Alyea, O. E., and Dannelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

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**Note:**

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*references:*


1. A. W. Spittler, Col., (M.C.), U.S.A., J. J. Brennan, Lt. Col., (M.C.), U.S.A., J. W. Payne, Capt., U.S.A.F. (M.C.), American Academy of Orthopedic Surgeons, Jan. 26-31, 1952, Chicago, Illinois.
2. M. C. Cobey, M.D., F.A.C.S., Professor of Orthopedic Surgery, Georgetown University and Senior Attending Orthopedic Surgeon, Children's Hospital, Washington, D. C., The American Surgeon, Vol. XVIII, No. 4, April, 1952, pp. 413, 415.
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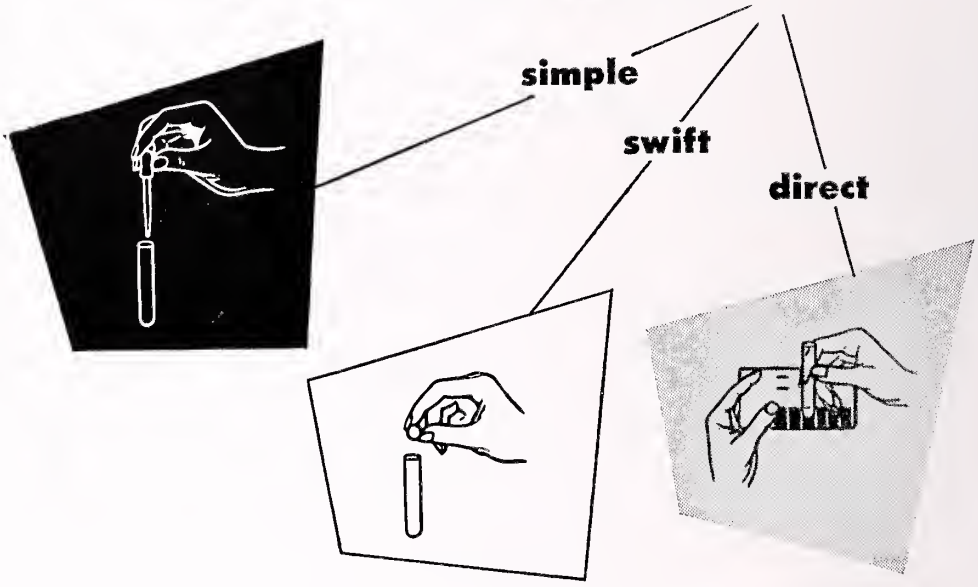




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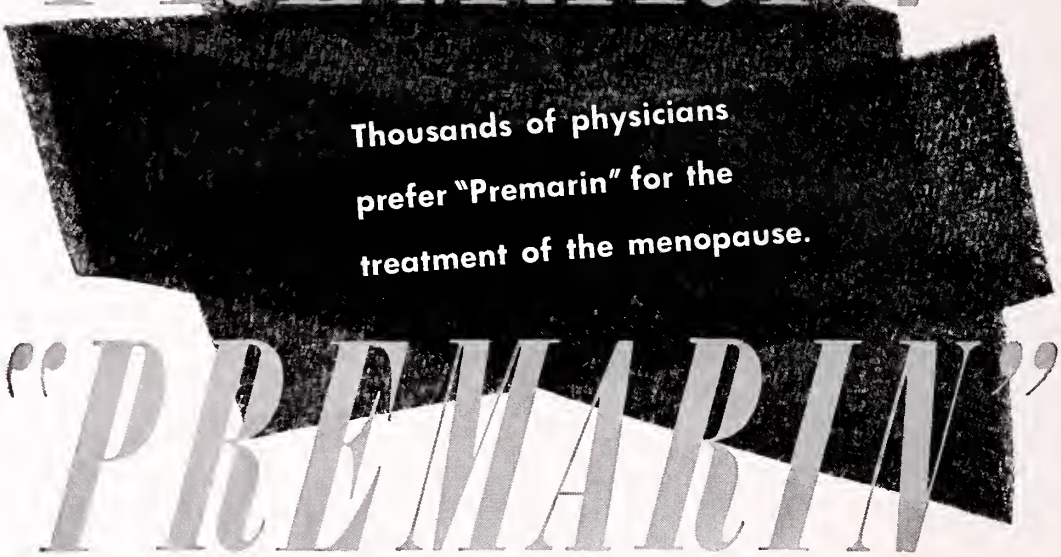
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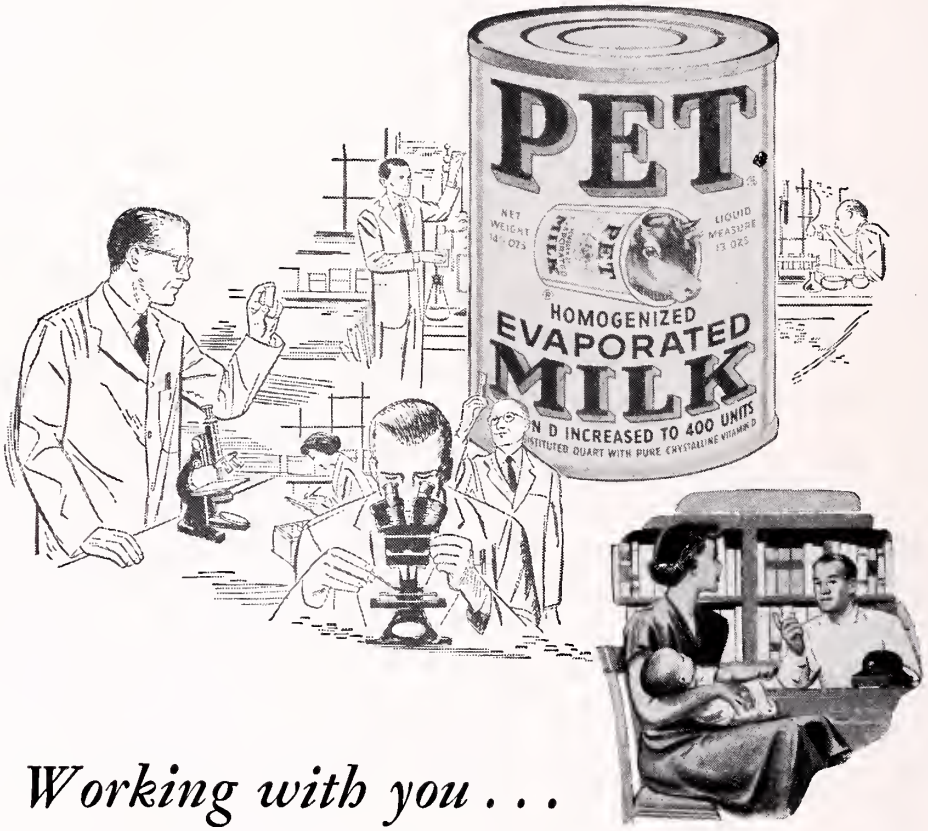
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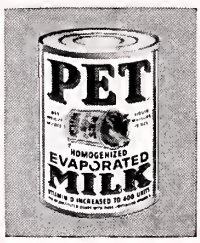



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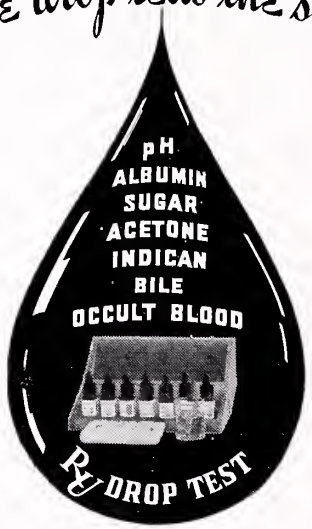
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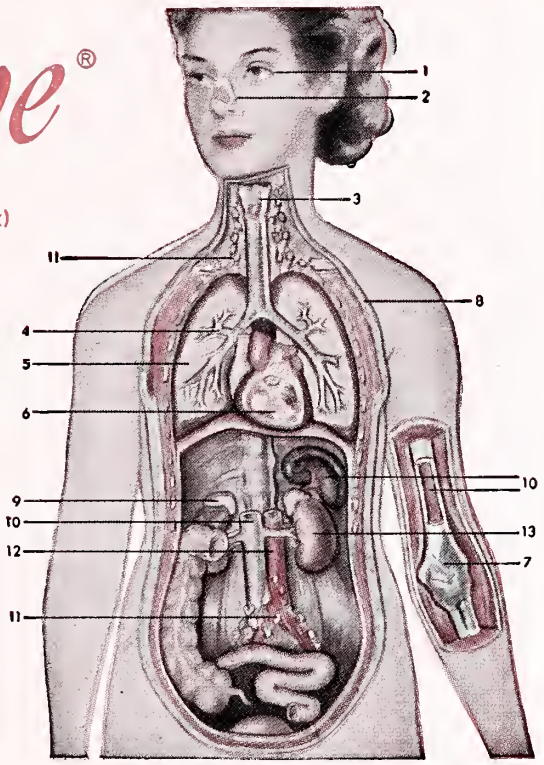
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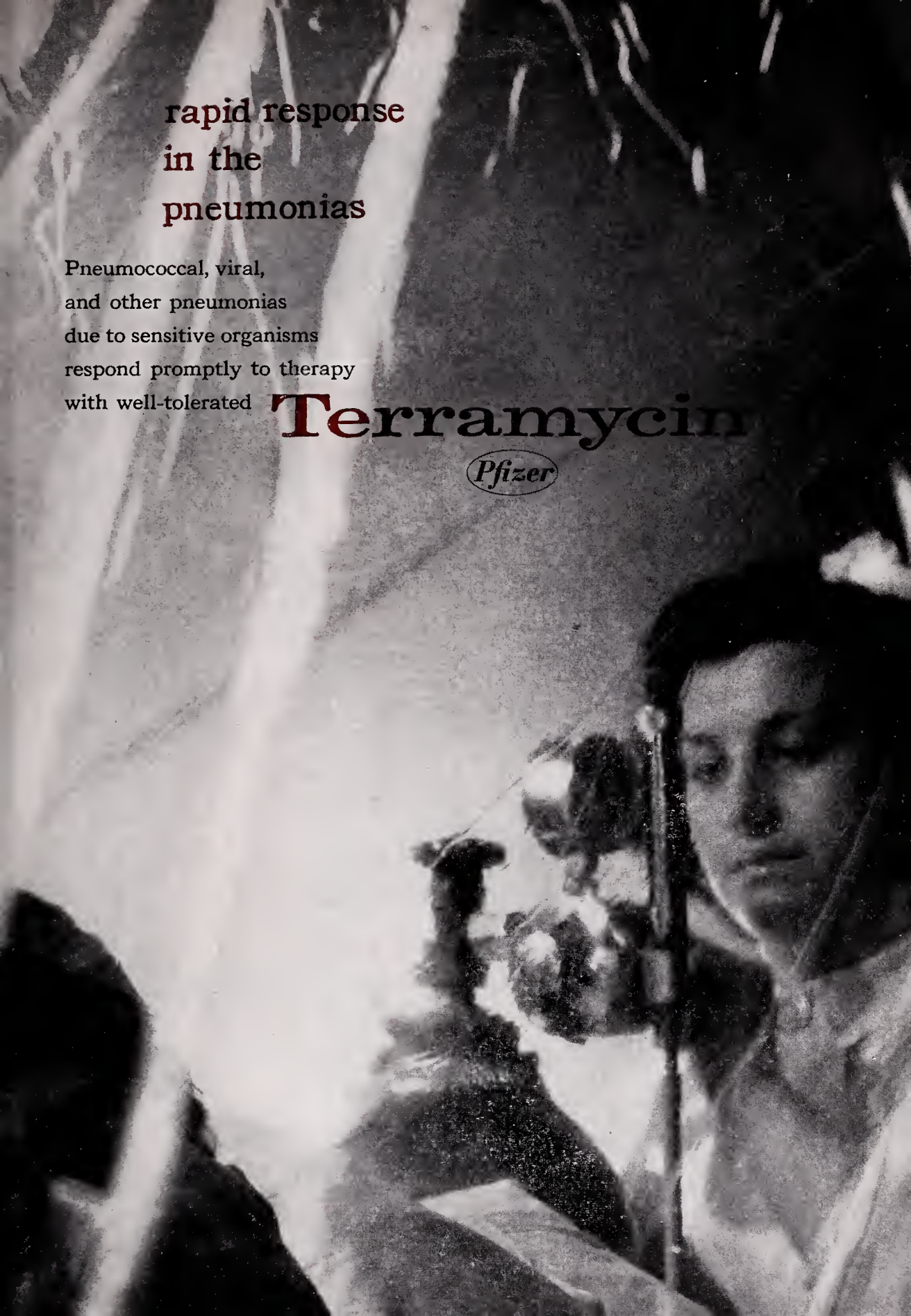
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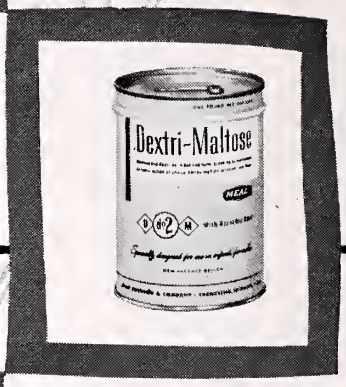
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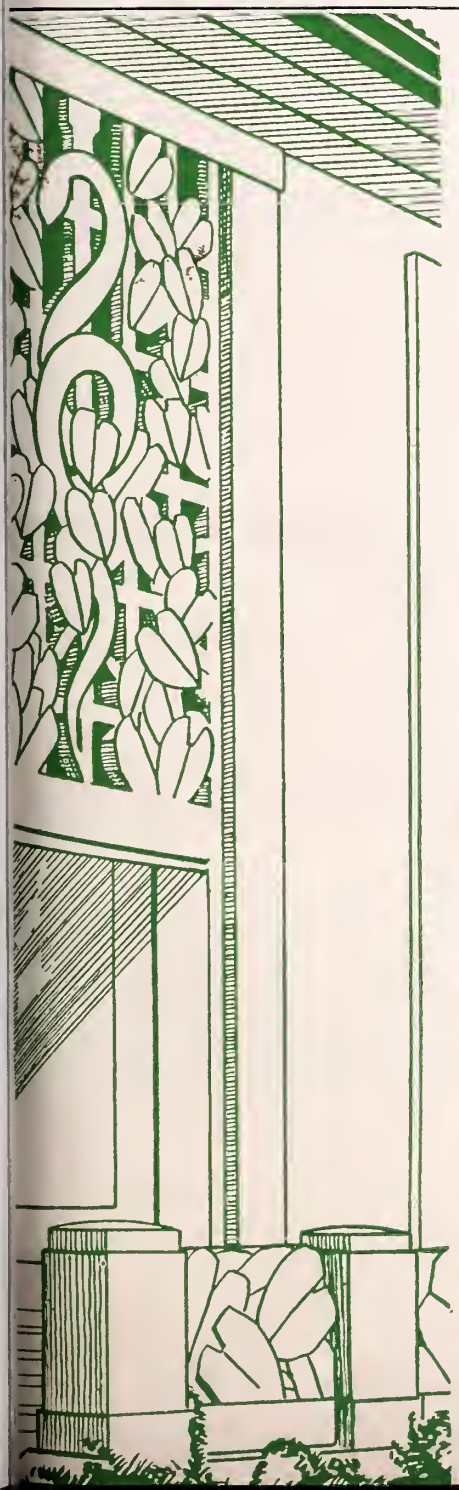
Designed and manufactured specifically for infant formulas, Dextri-Maltose® has an unequaled background of successful clinical use. Safety for your infant patients is assured by the dry form of this carbohydrate, meticulous laboratory control at all stages in its manufacture, and hermetically sealed, key-opening cans. Dextri-Maltose is palatable but not sweet; does not create a "sweet tooth" in infants. Easily measured without spilling or waste and almost instantly soluble, Dextri-Maltose is convenient for the mother.

# HAWAII MEDICAL JOURNAL

and

## INTER-ISLAND NURSES' BULLETIN

: 12 MARCH-APRIL, 1953 NUMBER 4


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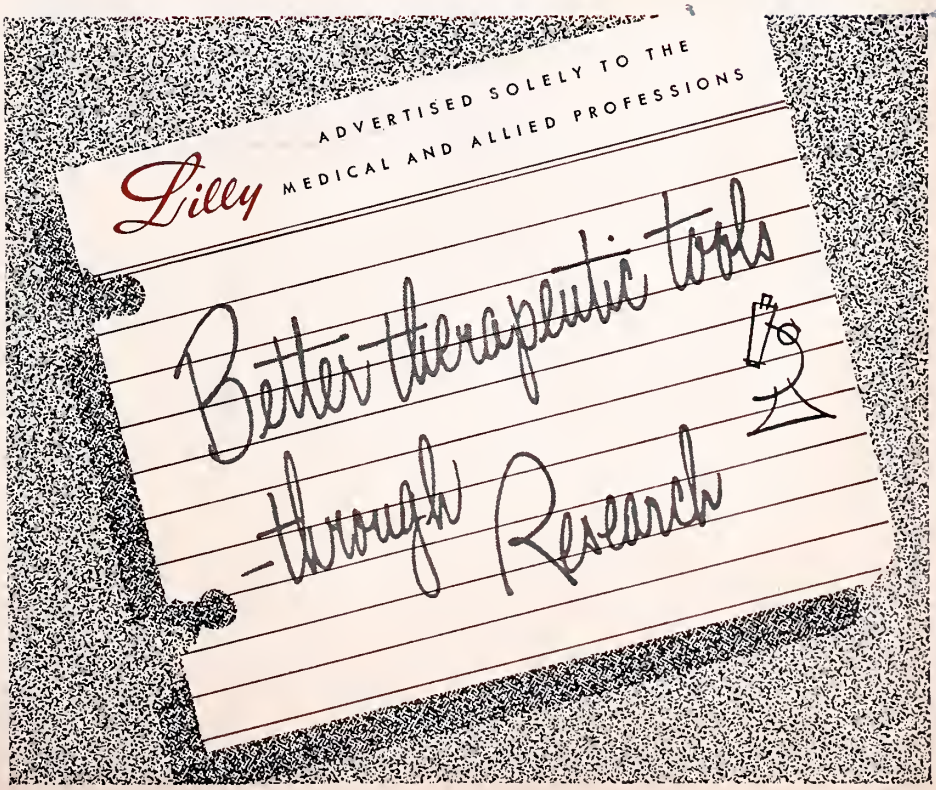

**ANNUAL MEETING, April 30 to May 3, 1953**

**WAILUKU, MAUI**

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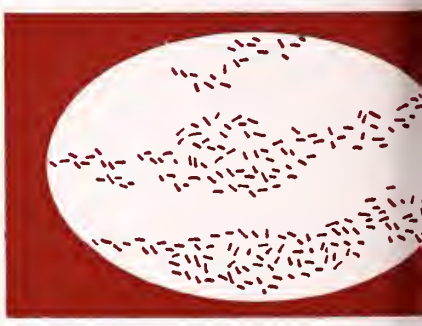


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# INTER-ISLAND NURSES' BULLETIN

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Number 4

MARCH-APRIL, 1953

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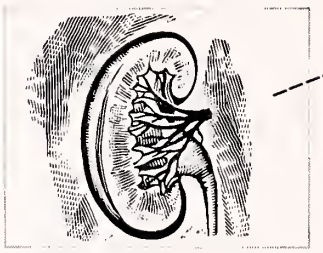

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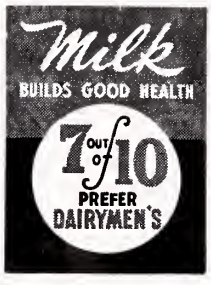
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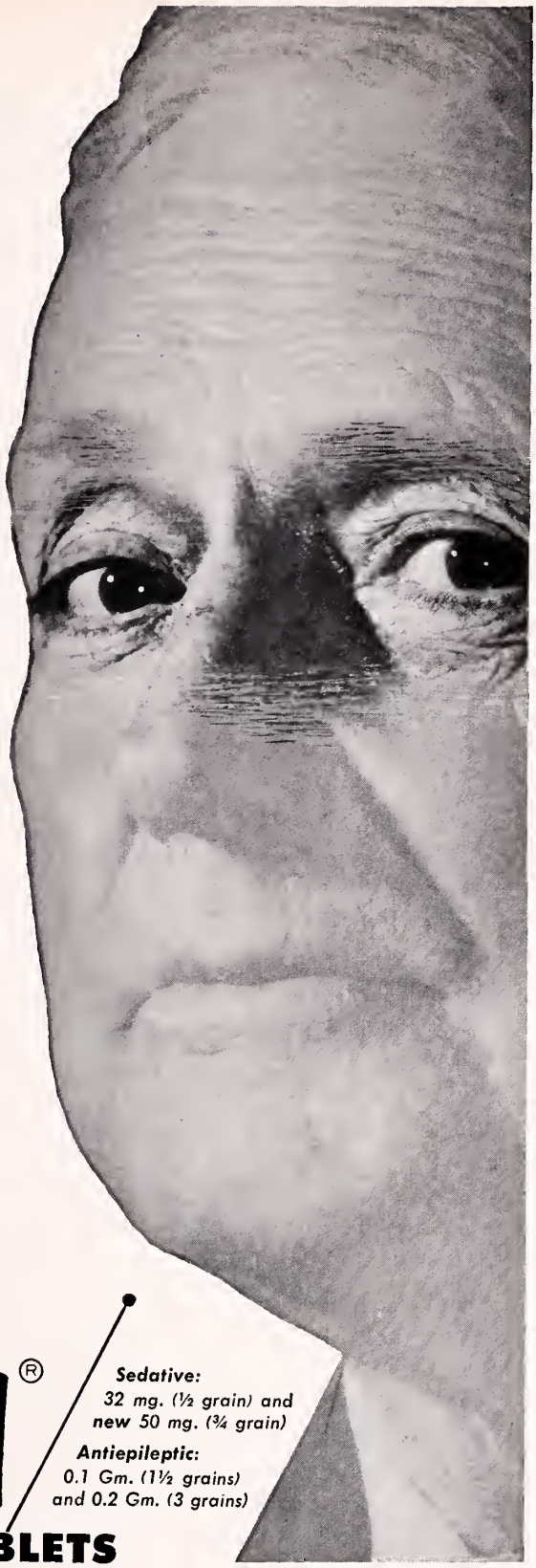
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***Sedative:***
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***Antiepileptic:***
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Better

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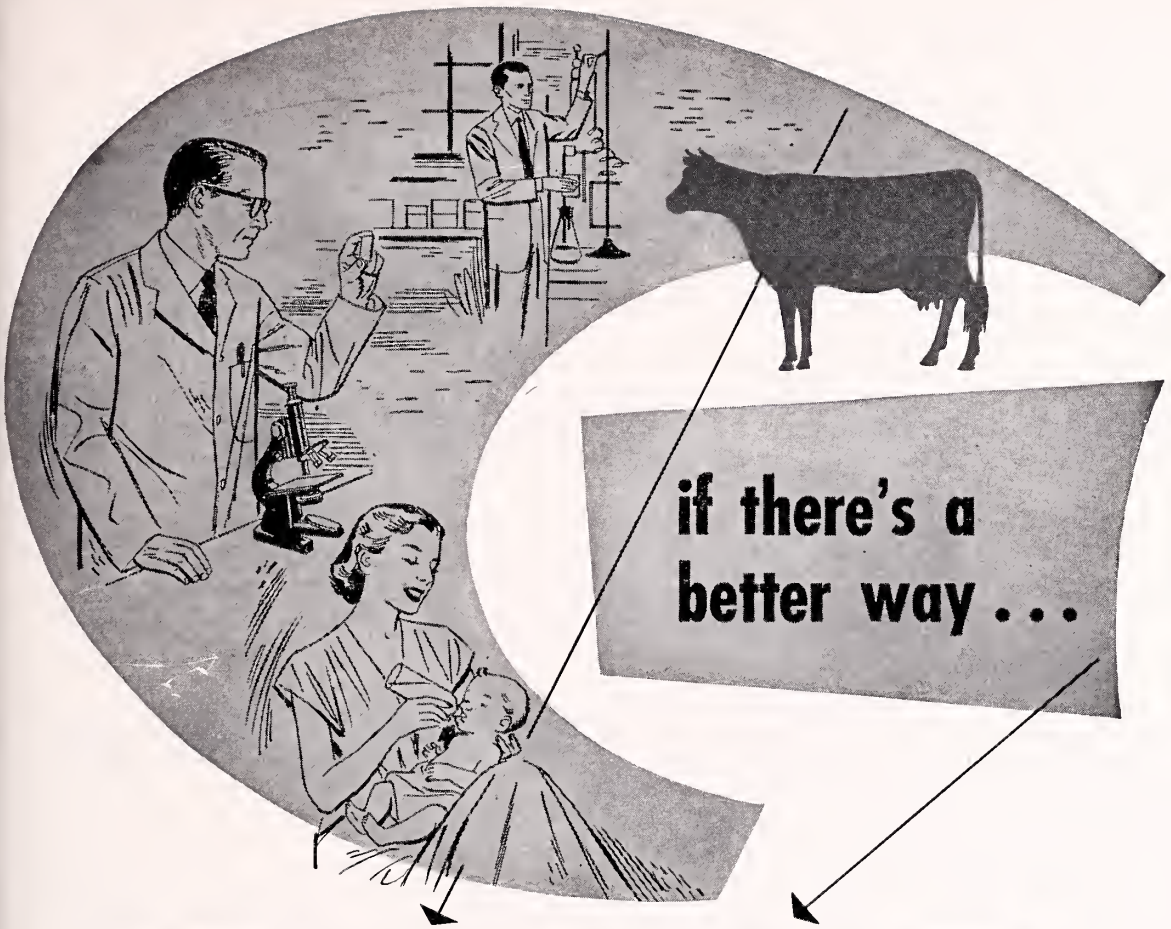
Sincerely yours,

L. H. Ashe

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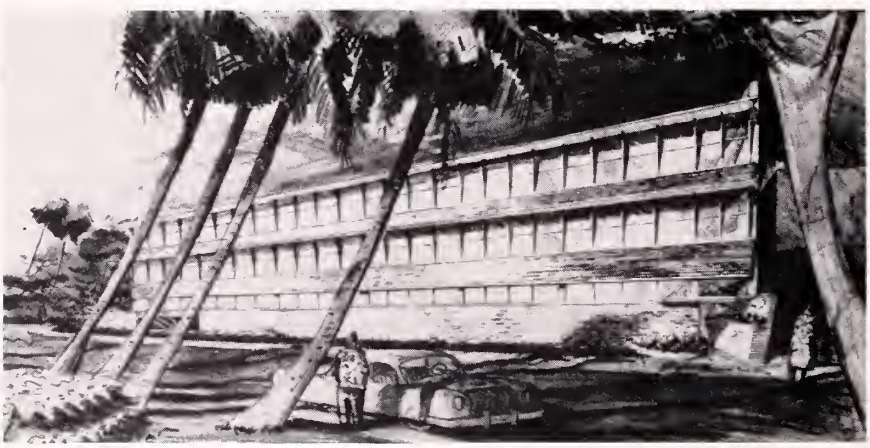
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Ethical
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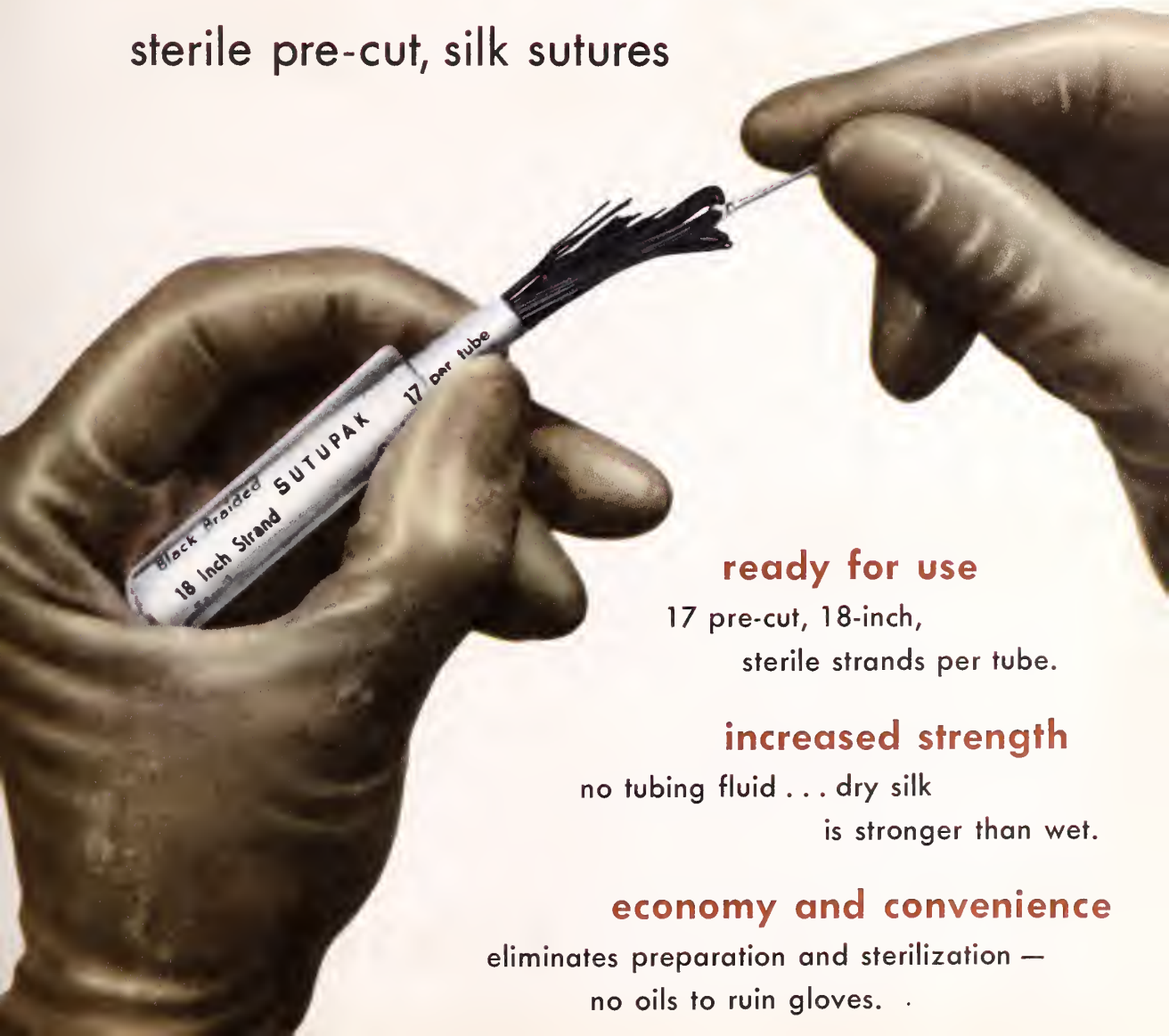
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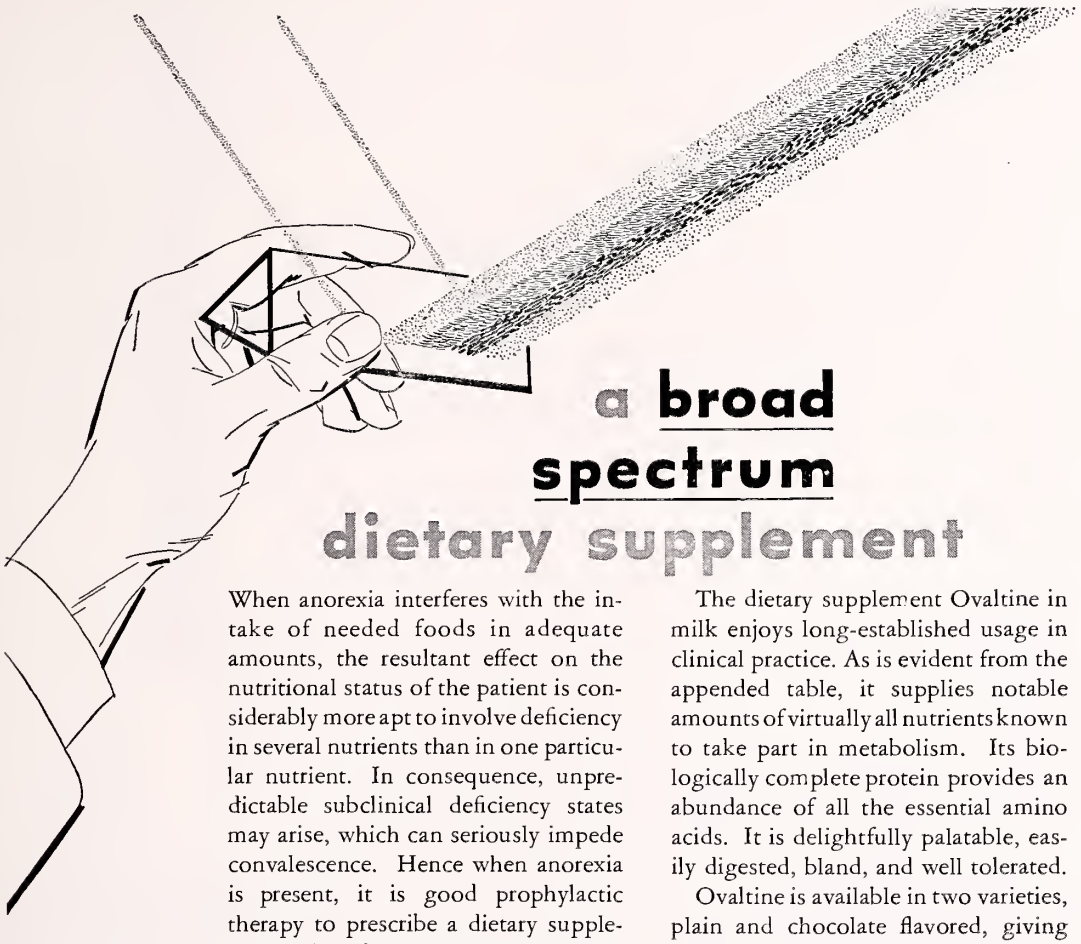
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(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

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| *CALCIUM | 1.12 Gm. | *ASCORBIC ACID | 37 mg. |
| CHLORINE | 900 mg. | BIOTIN | 0.03 mg. |
| COBALT | 0.006 mg. | CHOLINE | 200 mg. |
| *COPPER | 0.7 mg. | FOLIC ACID | 0.05 mg. |
| FLUORINE | 3.0 mg. | *NIACIN | 6.7 mg. |
| *IODINE | 0.15 mg. | PANTOTHENIC ACID | 3.0 mg. |
| *IRON | 12 mg. | PYRIDOXINE | 0.6 mg. |
| MAGNESIUM | 120 mg. | *RIBOFLAVIN | 2.0 mg. |
| MANGANESE | 0.4 mg. | *THIAMINE | 1.2 mg. |
| *PHOSPHORUS | 940 mg. | *VITAMIN A | 3200 I.U. |
| POTASSIUM | 1300 mg. | VITAMIN $B_{12}$ | 0.005 mg. |
| SODIUM | 560 mg. | *VITAMIN D | 420 I.U. |
| ZINC | 2.6 mg. | | |

| | |
|---|---|
| *PROTEIN (biologically complete) | 32 Gm. |
| *CARBOHYDRATE | 65 Gm. |
| *LIPIDS | 30 Gm. |

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

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**completely powered for modern driving**

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Model Pictured Above Is The 1953 | 205 H.P. V-8 Lincoln Capri Sedan

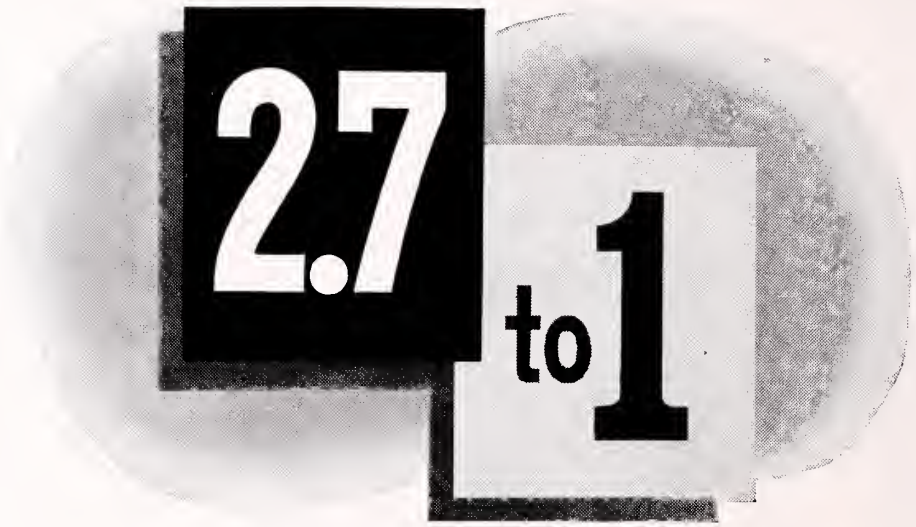


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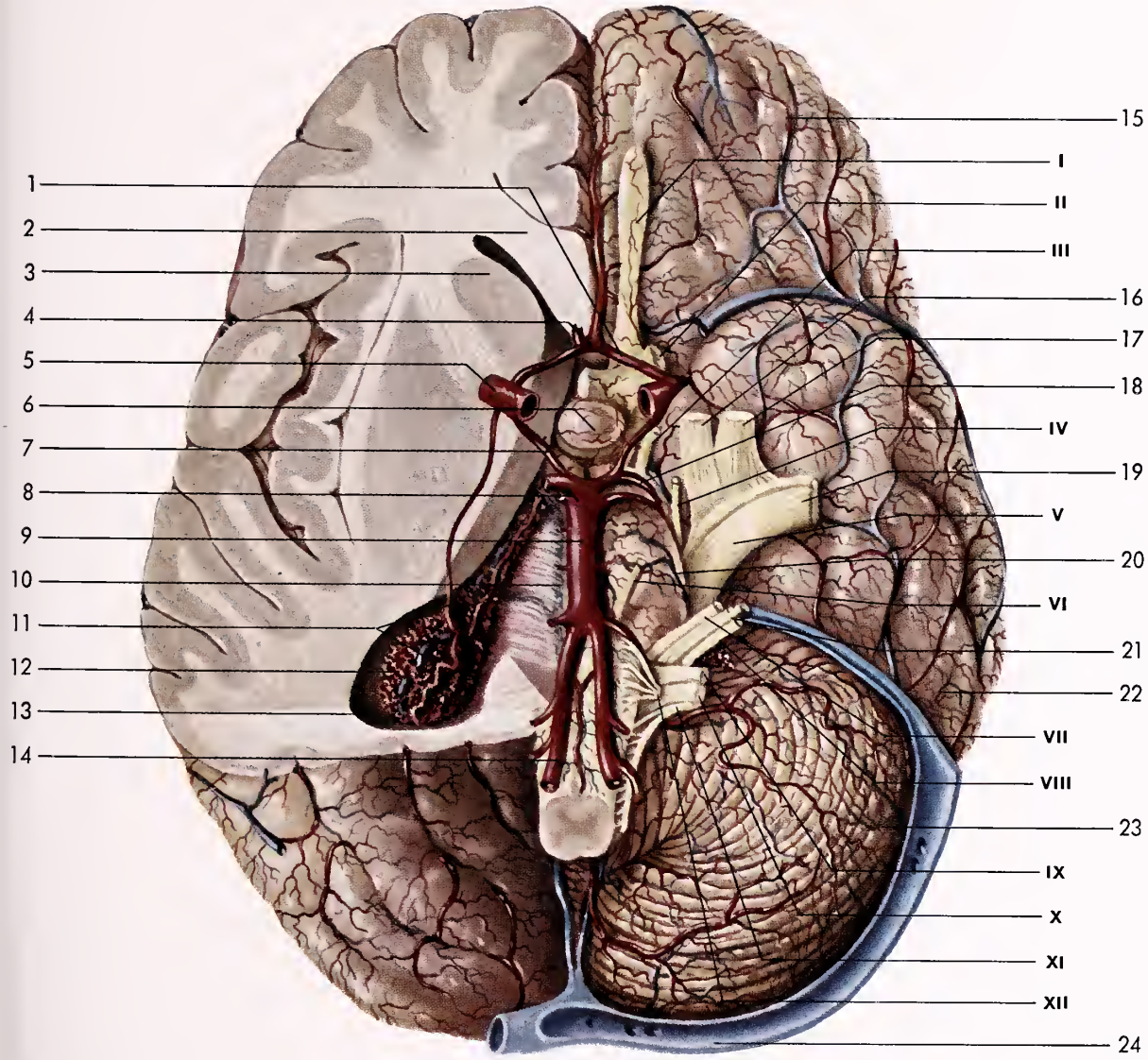

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# Anatomy *of the* Brain




1. Anterior cerebral artery
2. Trunk of corpus callosum
3. Head of caudate nucleus
4. Anterior communicating artery
5. Middle cerebral artery
6. Hypophysis
7. Posterior communicating artery
8. Superior cerebellar artery
9. Basilar artery
10. Internal cerebral vein
11. Choroid artery and vein
12. Choroid plexus of lateral ventricle
13. Inferior cornu of lateral ventricle
14. Vertebral artery
15. Frontal lobe
16. Ophthalmic nerve
17. Maxillary nerve
18. Posterior cerebral artery
19. Mandibular nerve
20. Pons
21. Intermediate nerve
22. Temporal lobe
23. Cerebellum
24. Left transverse sinus

CRANIAL NERVES

I. Olfactory nerve
II. Optic nerve
III. Oculomotor nerve
IV. Trochlear nerve
V. Trigeminal nerve
VI. Abducens nerve
VII. Facial nerve
VIII. Acoustic nerve
IX. Glossopharyngeal nerve
X. Vagus nerve
XI. Accessory nerve
XII. Hypoglossal nerve

*This is one of a series of paintings by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.*

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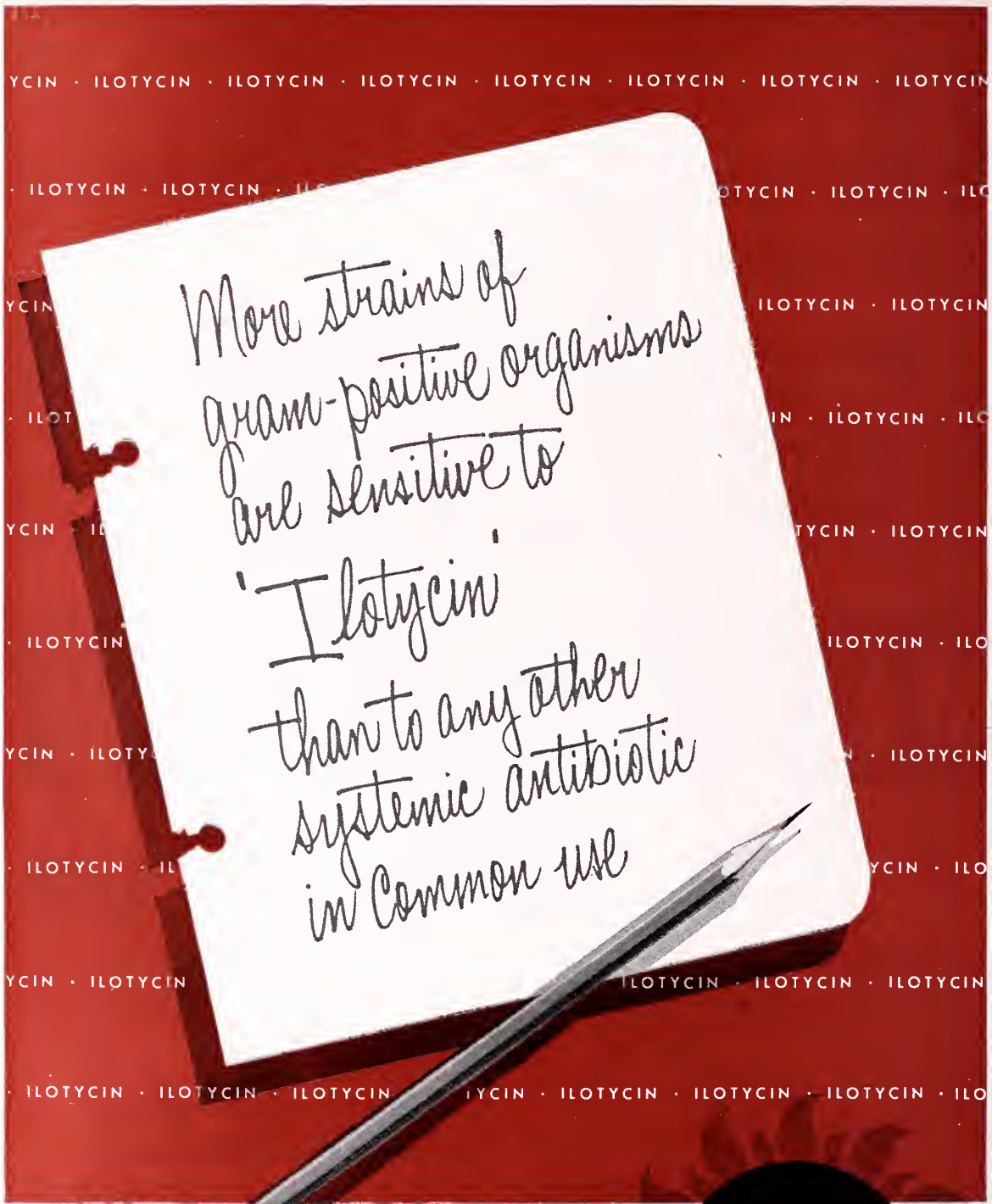
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# The Removal of Normal Ovaries

C. C. McCORRISTON, M.D., AND C. M. VAN DUYNE, M.D.

HONOLULU

SINCE Ephraim McDowell performed the first ovariotomy in 1809, countless thousands of ovaries—a good many of them normal—have reached the pathologist. Mengert[1] has pointed out that in a certain well conducted hospital 75 per cent of 1320 ovaries removed over a period of four years were found to be structually normal. Emge,[2] Miller,[3] Doyle,[4] and one of us (CCM)[5] have expressed the need for more thoughtful treatment of the ovary. We thought it would prove interesting to review the charts of those patients subjected to ovarian surgery in the Kapiolani Maternity and Gynecological Hospital, an "open staff" hospital at which 108 physicians had surgical privileges in January, 1951.

The records of 323 patients who had one or both ovaries removed in this institution during a four-year period, January, 1947, to January, 1951, were reviewed. Table 1 shows that a total of 485 ovaries were removed, 339 in conjunction with hysterectomy. Two hundred forty-one of these ovaries were from women under 41 years of age.



DR. McCORRISTON

In Table 2 are listed the various pathologic diagnoses of the ovarian specimens, distributed according to age of patients.

Three hundred twenty-one ovaries (Table 3) were 5 cm. or less in the largest listed dimension.

For the purpose of this paper, a "normal" ovary is defined as one 5 cm. or less in its largest dimension and possessing only structures representing common physiologic events in the life of the ovary. Using this criterion, we found that for the series 62.2 per cent of the ovaries extirpated were structurally normal.

Considering separately the records of 127 patients in whom the ovary was the primary target of the operator, there were 100 instances in which but a *single* ovary was removed. Thirty-six per cent of these ovaries were 5 cm. or less in the largest listed dimension and showed microscopically only follicle or luteal cysts, or both.

Of 19 patients subjected to bilateral oophorectomy, bilateral dermoids accounted for the procedure in 6. Hydrosalpinx or peri-oophoritis, or

TABLE 1. *Procedures, by age groups.*

| | AGE GROUP (*arbitrary*) | | |
|---|---|---|---|
| | *Under 40* | *Over 40* | *Total* |
| Unilateral oophorectomy | 90 | 10 | 100 |
| Bilateral oophorectomy | 14 | 5 | 38 |
| Hysterectomy and bilateral oophorectomy | 43 | 100 | 286 |
| Hysterectomy and unilateral oophorectomy | 29 | 24 | 53 |
| Appendectomy and oophorectomy | 8 | 0 | 8 |
| | | | 485 |

TABLE 2. *Pathologic diagnosis by age groups.*

| | AGE GROUPS | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *25* — | *26 to 30* | *31 to 35* | *36 to 40* | *41 to 45* | *46 to 50* | *51 to 60* | *61 plus* | TOTAL | PER CENT |
| Follicle and/or luteal cysts | 13 | 19 | 39 | 41 | 90 | 57 | 20 | 5 | 284 | 58.5 |
| Fibrosis and atrophy | 0 | 0 | 0 | 2 | 10 | 10 | 13 | 0 | 35 | 7.2 |
| Endometriosis | 1 | 8 | 3 | 7 | 11 | 3 | 0 | 0 | 33 | 6.8 |
| Non-specific simple cysts | 3 | 7 | 11 | 4 | 1 | 0 | 1 | 0 | 27 | 5.5 |
| Salpingitis and/or peri-oophoritis | 4 | 8 | 8 | 6 | 1 | 0 | 0 | 0 | 27 | 5.5 |
| Dermoid | 7 | 11 | 4 | 1 | 2 | 0 | 0 | 0 | 25 | 5.1 |
| Pseudomucinous cystadenoma | 2 | 4 | 4 | 0 | 0 | 1 | 1 | 0 | 12 | 2.6 |
| Tubo-ovarian abscess-hydrosalpinx | 5 | 0 | 1 | 1 | 3 | 0 | 0 | 0 | 10 | 2.2 |
| Serous cystadenoma | 2 | 0 | 3 | 1 | 3 | 0 | 0 | 0 | 9 | 2.0 |
| Carcinoma (papillary serous) | 0 | 0 | 0 | 2 | 1 | 0 | 2 | 0 | 5 | 1.0 |
| Parovarian cyst | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 4 | 1.8 |
| Granulosa cell tumor | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 4 | 1.8 |
| Fibroma | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0.2 |
| Calcified hematoma | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0.2 |
| Pathologic report not available | 0 | 0 | 0 | 3 | 0 | 3 | 2 | 0 | 8 | 1.6 |

From the Kapiolani Maternity and Gynecological Hospital. Received for publication June 6, 1952.

[1] Mengert, W. F.: Physiologic Approach to the Problem of Oophorectomy, Texas State J. Med. 41:465 (Jan.) 1946.

[2] Emge, L. A.: Indications for Surgery of the Ovary, Calif. Med. 67:211 (Oct.) 1947.

[3] Miller, N. F.: The Perpetuation of Error in Obstetrics and Gynecology, J.A.M.A. 117:905 (Sept. 13) 1941.

[4] Doyle, J. C.: Unnecessary Ovariectomies, J.A.M.A. 148:1105 (Mar. 29) 1952.

[5] McCorriston, C. C.: Term Pregnancy Following Conservative Removal of Bilateral Dermoid Cysts, Proc. Staff Meet. The Clinic, Honolulu, 12:11 (Nov.) 1946.

both, with associated salpingitis, was found in 5. In 2 patients inspection of the ovaries revealed only follicle or luteal cysts, or both. In 3 patients the contralateral ovary was removed in conjunction with removal of a pseudomucinous or serous cystadenoma. One patient had bilateral endometriosis; one patient, fibrosis and atrophy; and in one patient a bilateral papillary serous cystadenocarcinoma was found. Eighteen per cent of the 38 ovaries removed from these patients were 5 cm. or less in their largest dimension and revealed only follicle or luteal cysts, or both, on microscopic section.

TABLE 3. *Size of the ovaries removed according to age groups.**

| AGE GROUPS | SIZES | | | | | | |
|---|---|---|---|---|---|---|---|
| | *5 cm. or less* | *6 cm.* | *7 to 11 cm.* | *11 to 16 cm.* | *16 to 26 cm.* | *26 to 41 cm.* | *Over 41 cm.* |
| Under 25 | 15 | 8 | 6 | 4 | 2 | 1 | 0 |
| 26 to 30 | 24 | 5 | 4 | 7 | 2 | 0 | 0 |
| 31 to 35 | 48 | 4 | 8 | 2 | 2 | 0 | 2 |
| 36 to 40 | 45 | 3 | 6 | 2 | 0 | 0 | 0 |
| 41 to 45 | 96 | 1 | 3 | 4 | 0 | 0 | 0 |
| 46 to 50 | 58 | 0 | 0 | 1 | 0 | 0 | 0 |
| 51 to 60 | 30 | 1 | 1 | 1 | 1 | 1 | 0 |
| Over 61 | 5 | 0 | 0 | 1 | 0 | 0 | 0 |

*The sizes listed are in centimeters and are a measure of the largest listed dimension of the ovary as obtained from the pathologic report. No size was listed for eighty-one extirpated ovaries.

When we consider those 8 patients from whom an ovary and the appendix were removed, all had the common symptom of pain. There were 2 ruptured corpus luteum cysts, 3 simple cysts, 1 dermoid cyst and 2 follicle cysts. Only 2 of these ovaries were over 5 cm. in the largest dimension —the dermoid and a simple cyst.

## Conclusions

1. Using our criteria, 62 per cent of the ovaries removed in this series were considered structurally normal.

2. Most cystic ovarian enlargements 5 cm. or less in diameter represent physiological ovarian changes.

3. Surgeons performing ovarian surgery should be thoroughly familiar with gross ovarian physiology.

4. This study suggests that a more conservative attitude toward the female gonad would be beneficial.

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**Bronchial Resection and Anastomosis**
PAUL W. GEBAUER, M.D.

**Harada's Disease**
H. E. CRAWFORD, M.D.

**The Effect of Kona Weather on the Asthma Incidence in Children**
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**Panel Discussions on Cardiovascular Surgery, Cancer Diagnosis and Therapy, Industrial Surgery and Medical Economics**

# The Place of Radical Surgery for Cancer of the Uterus

R. G. HUNTER, M.D.

HONOLULU



DR. HUNTER

THE pendulum of medical philosophy has swung between complete radicalism and do-nothing conservatism for as long as there has been illness. It will continue to swing in progressively smaller arcs as more discoveries are made and better methods are found. This appears to be particularly true in regard to the treatment of cancer.

In previous discussions of this sort there has always been a sort of contest between the gynecologist and the radiologist as to who offered the best treatment. There have been too few discussions which presented the view that proper radiological and surgical treatment complemented each other, and were in no way mutually exclusive. It is not the object of this paper to argue with my good friends, the radiologists. All that follows is based on the premise that adequate treatment be furnished by the radiologist. I am quite confident that the statistics of the future will bear me out.

So long as there is ignorance of many of the fundamental facts about cancer, there will be scope for any treatment that will do good empirically.[1] This is true of surgery, for no one will dispute the axiom that so long as a cancer is extirpated early enough and sufficiently radically, there can be no recurrence. The present trend is a combination of radiotherapy combined with surgery in judiciously selected cases.

### Anatomical Considerations

A review of some salient anatomical facts is in order. In a study of necropsy material from 64 cases of adenocarcinoma of the corpus and 356 cases of carcinoma of the cervix, Henriksen observed the following:[2]

Fig. 1 shows the potential routes of metastases. The two groups of nodes are here shown:

1. The primary nodes.
   a. The parametrium. Small nodes along the major trunks traversing the parametrium.
   b. The paracervical or ureteral node, located near the crossing of uterine artery and the ureter.
   c. The hypogastric nodes. These uniformly small nodes are located along the hypogastric vein near its junction with the iliac vein.
   d. The obturator nodes varying from one large to three small nodes, associated with the nerve and obturator vessels near the obturator fossa.
   e. The external iliac nodes found on the mesial surface of the iliac vein in the sulcus between the vein and artery.
2. The secondary nodes.
   a. Sacral nodes of the sacral concavity and promontory.
   b. Common iliac nodes lie on the medial and lateral surfaces of the common iliac vessels just below the bifurcation to the diaphragm.

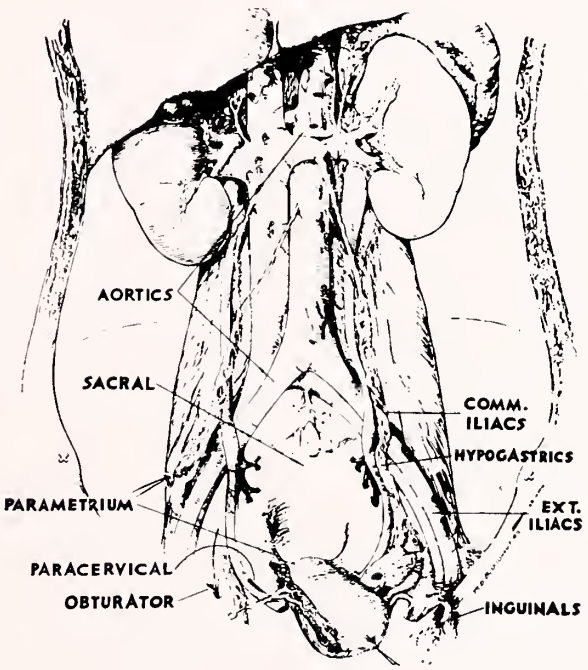



FIG. 1. Potential routes of metastases. From Henriksen.

Whereas the parametrium of the untreated cases showed 77 per cent infiltration, only 33 per cent of the treated cases showed such evidence. In that treated group only 70 per cent showed node changes usually attributable to radiation effect. Nor were all the metastatic cancer-bearing nodes free of evidence of cancer.

Read before the Sixty-second annual meeting of the Hawaii Territorial Medical Association, May 2, 1952.

[1] Stacey, J. E., in Bowes, K.: Modern Trends, Obstetrics & Gynecology, New York, Hoeber, 1950, p. 675.

[2] Henriksen, E.: The Lymphatic Spread of Carcinoma of the Cervix and of the Body of the Uterus, Am. J. Obst. & Gynec. 58:924 (Nov.) 1949.

In the entire series of 356 cases distant metastases were present in 37.8 per cent of the treated and 32.5 per cent of the untreated cases.

Fig. 4 shows the incidence of distant metastases in 154 cases of untreated cervical carcinoma. In no case was there involvement by distant metastasis without primary group involvement.

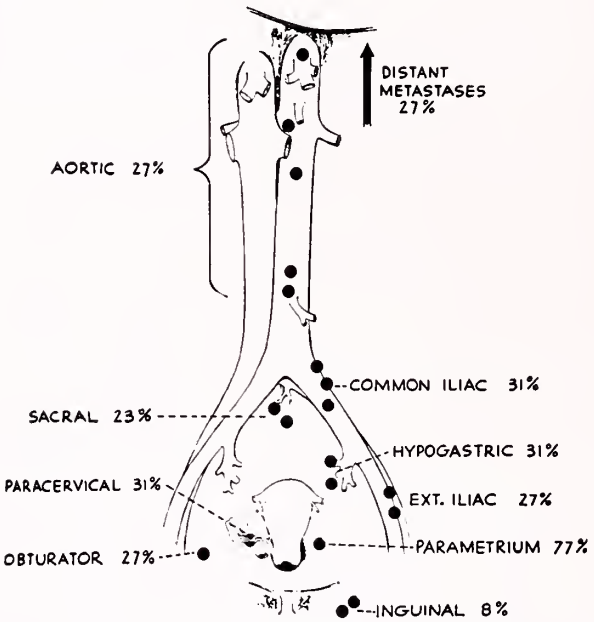



FIG. 2. Incidence of node group involvement in 26 non-treated cases of cervical carcinoma. From Henriksen.

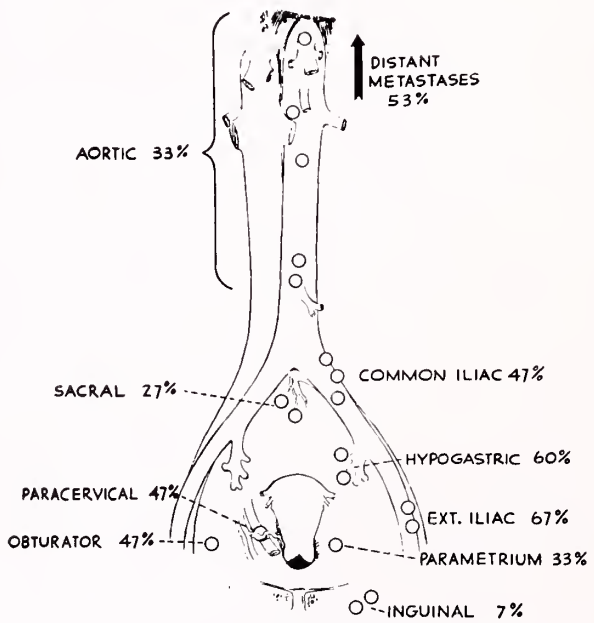



FIG. 3. Incidence of node involvement in 15 cases of treated cervical carcinoma. From Henriksen.

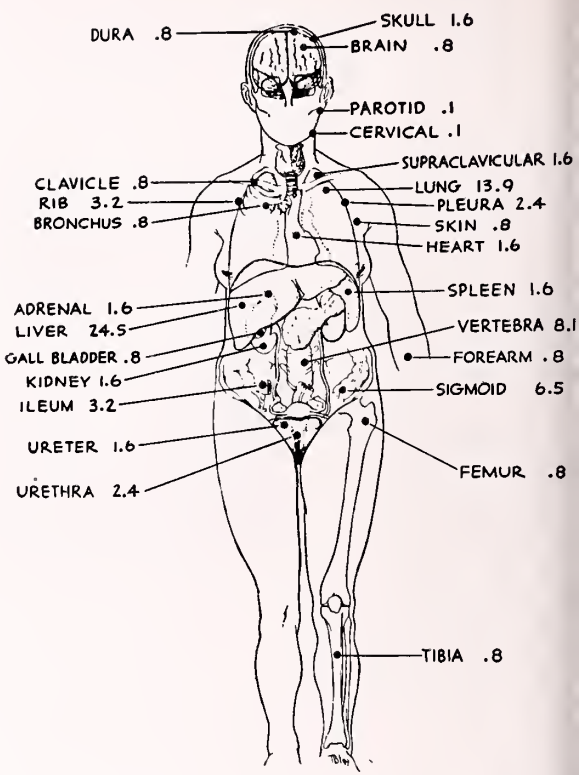



FIG. 4. Incidence of distant metastases in 154 cases of untreated cervical carcinoma. From Henriksen.

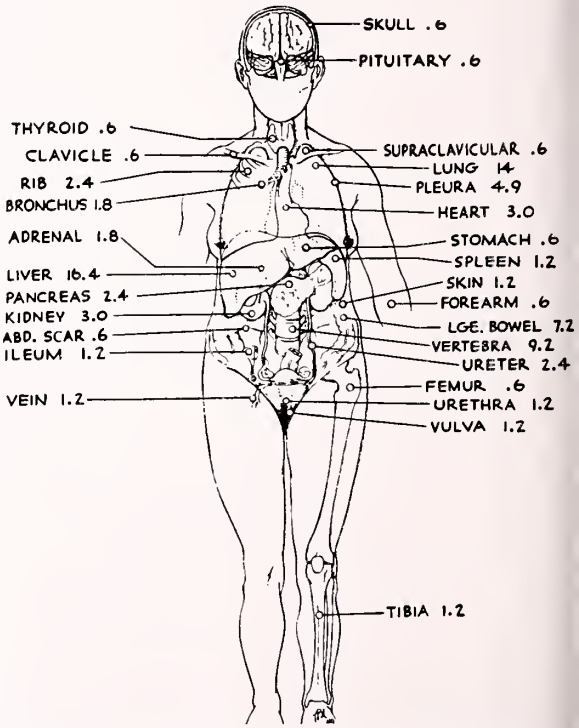



FIG. 5. Incidence of distant metastases in 202 treated cases of carcinoma of the cervix. From Henriksen.

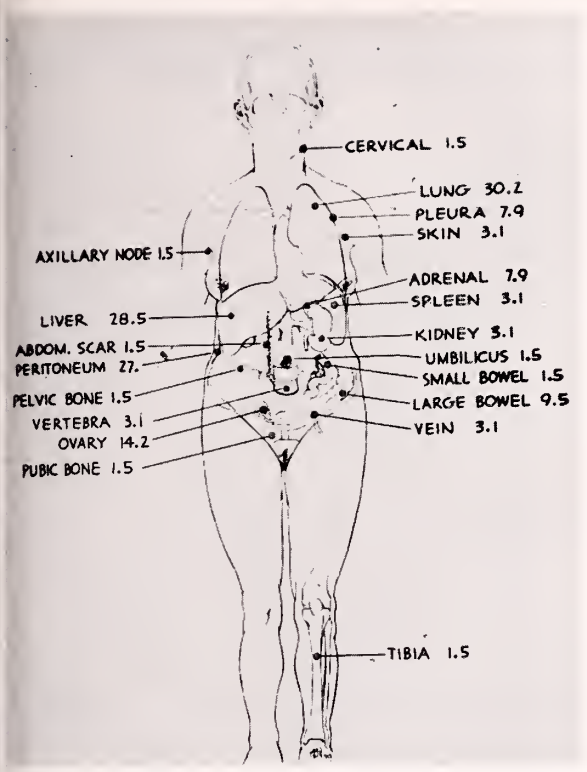



FIG. 6. Incidence of distant metastases in 64 cases of corporeal carcinoma. From Henriksen.

These cases with this careful complete study add further evidence to the knowledge of lymphatic spread. It is by way of the paramatrium, the nodes of the primary group and finally the secondary group before extension beyond the limits of the bony pelvis.

The routes of spread of carcinoma of the fundus are less constant. The three main channels permit involvement of the same nodal groups as found in cervical carcinoma or a by-passing of the primary groups with metastases directly to inguinal or aortic nodes.

In any case, it may be assumed that the process is confined to the pelvis for a relatively long time. Treatment, therefore, of the local lesion to reduce the activity and the usually concurrent inflammatory process, followed by radical surgery in selected cases, offers a far better chance of recovery than the 50 per cent that we are now so proud to quote as the best in the world.

## Indications for Surgery

The selection of cases for surgery in various centers differs greatly. C. D. Read[3] requires one or more of the following:

1. Radio-resistance, either clinical or cytological.
2. Columnar cell carcinoma of the cervix.
3. Stenosis of the vaginal vault, preventing adequate placement of radiation.
4. Fibroids or cysts as a complication.
5. Salpingitis.
6. Refusal of radiation.

J. V. Meigs[4] prerequisites are:

1. League of Nations Stage 1 or 2.
2. Patients who are thin and have adequate veins for support during the critical postoperative period.
3. Those whose age offers a long life span under any circumstances.
4. Those whose hematological and chemical balance can be brought to normal easily.

These indications have now been broadened to allow those of his group to operate upon 50 per cent of all patients presenting themselves, regardless of stage. He favors the surgical approach because:[5]

1. If the cervix has been removed, there is no chance of recurrence in it.
2. Some cancers of the cervix are radiation resistant.
3. Some patients with cancer of the cervix, even when there is extensive lymph node involvement, can be cured by surgery but not by radiation.

Alexander Brunschwig[6, 7] has divided his cases into categories and varies his operative technic as follows:

1. When irradiation has failed and the disease is still localized in the cervix and upper vagina, a radical hysterectomy and gland dissection is carried out.
2. When there is recurrence and involvement of the rectum, the radical hysterectomy with gland dissection is done, with local excision of the involved area of the rectum.
3. When the bladder is involved, it is removed as part of the radical hysterectomy and gland dissection, the ureters being implanted into the colon.
4. When the bladder and rectum are both involved, a pelvic exenteration with transplant of the ureters and a colostomy are performed.

In a personal communication, M. B. Dockerty[8] of the Mayo Clinic reviewed the practices of that group.

> All in situ cancers of the cervix are treated solely by vaginal or abdominal simple hysterectomy preserving the ovaries. If there are contraindications to operation (rare) radium is employed. Our current incidence of situ growths is no less than 33 per cent of the total seen, thanks to a vigorous smear-screening program.

[3] Read, C. D.: The Role of Surgery in the Treatment of Carcinoma of the Cervix, Am. J. Obst. & Gynec. 56:1021 (Dec.) 1948.

[4] Meigs, J. V., in Bowes, K.,[1] p. 681.

[5] Meigs, J. V., in Meigs, J. V. & Sturgis, S. H.: Progress in Gynecology, Vol. II, New York, Grune & Stratton, 1950, p. 540.

[6] Brunschwig, A.: The Surgical Treatment of Cancer of the Cervix Uteri, Bull. New York Acad. Med. 24:672 (Oct.) 1948.

[7] Brunschwig, A. and Pierce, V. K.: Partial and Complete Pelvic Exenteration, Cancer 3:972 (Nov.) 1950.

[8] Dockerty, M. B. (1952) Personal communication.

All other cases are treated primarily by irradiation. Radium for the local growth and x-ray for the nodes. On the three-month checkup (which is routine) a surgeon is called in consultation. If things are mobile he does a pelvic housecleaning *including the uterus, tubes,* ovaries and nodes. Currently, however, those with positive peri-aortic nodal involvement are closed as explorations. These as well as the cases with clinical stage 4 lesions noted at the time of re-evaluation are given further irradiation.

### Radical Surgery

The indications for radical surgery vary in degree, the one consistent indication being lack of response to radiation. This may be determined on a clinical basis with palpable or visible evidence of continuation or recurrence of the malignant process or the response may be gauged on a cytological basis. Two methods have been proposed: (1) That of Glucksmann[9] and Spear, using tissue biopsies, and (2) the method of Ruth Graham,[10] using vaginal smears.

The Glucksmann and Spear method is based upon proportions of tumor cells in selected areas of serial biopsies taken before, during, and after treatment.

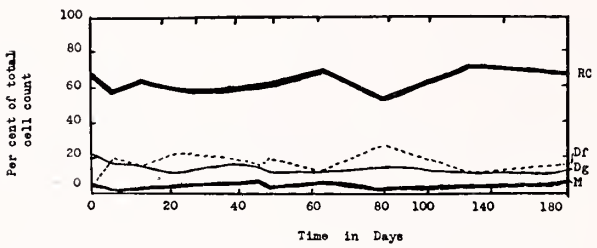



FIG. 7. Minor variations in cell counts, indicating persistent growth of tumor and unsatisfactory response to treatment. From Glucksmann.

Fig. 7 shows the graph plotted on the basis of counts of cells from routine serial biopsies in a case of carcinoma of the cervix treated by routine radiotherapy. Only minor variations in cell counts are seen, thus indicating the persistent growth of the tumor and an unsatisfactory response to treatment. The growth persisted in spite of early, temporary clinical response; the patient died seven months after the beginning of treatment.

Fig. 8 shows the graph with marked decrease in the percentage of viable cells, indicating a temporary response to treatment followed by regrowth. Clinically, the lesion disappeared but recurred in the treated area; the patient died sixteen months after the beginning of treatment.

Fig. 9 shows the progressive diminution and final disappearance of all viable cells, indicating local cure. Clinically, the lesion disappeared entirely, and the patient was alive and free of growth seven years after treatment.

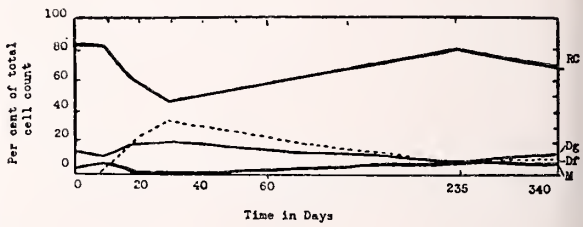



FIG. 8. Temporary response to treatment followed by regrowth. From Glucksmann.

The cytological method of Ruth Graham and the Vincent Memorial Hospital is based on the cytological response of malignant and unusual cells to radiotherapy as seen in vaginal smears.

The smears are taken at three-day intervals and the effects followed. Those patients showing satisfactory smear response can be offered a much more favorable prognosis and may not need to be subjected to surgery. Those with unsatisfactory response may be evaluated as surgical problems.

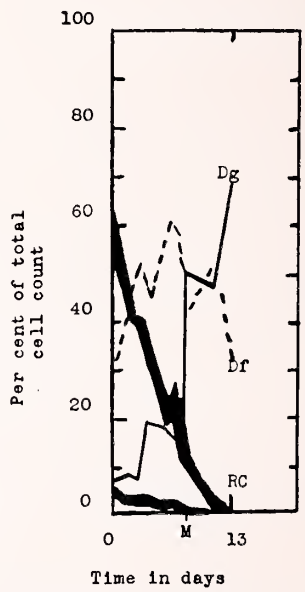



FIG. 9. Progressive diminution and final disappearance of all viable cells, indicating local cure. From Glucksmann.

Staging carcinomas of the cervix is necessary, but the percentage of error will vary greatly; some set it at 30 per cent. When first seen, there may be a great deal of complicating inflammatory reaction which gives the impression of fixation and or invasion. On this basis the patient's

[9] Glucksmann, A.: Recent Advances in Clinical Pathology, Philadelphia, Blakiston, 1948, p. 338.

process is classified as Stage III or IV and unfortunately may be relegated to the inoperable group only to find that after adequate radiation, in spite of continued growth of the primary malignancy, the staging can be changed to the easily operable class of I or II. It is often easier to do surgery in a Stage III patient than a Stage I or II, and no amount of guesswork will accurately tell the ease with which the dissection can be done.

The operations usually done for the foregoing conditions may vary from a simple but complete surgical amputation of the cervix for a carcinoma in situ, nothing more being done if on serial section no invasive cells can be found, to a complete pelvic exenteration when there is involvement of the rectum and bladder without evidence of growth out of the pelvis. The trend of thinking in carcinoma of the fundus is more toward adding gland dissection to the already established wide hysterectomy.

Any radical surgery of this type must be preceded by adequate studies of the urinary tract and bowel as well as the establishment of almost perfect preoperative chemical and blood balance.[10] Cystoscopy and pelvic examination with the cystoscope in the bladder is carried out. Evidence of invasion of the bladder base, such as induration, edema of the mucosa, or loss of mobility of the base contra-indicate the radical hysterectomy, and more radical surgery may be considered. By the use of intravenous pyelograms, partial or complete obstruction may be shown and transplantation of the ureters may give better results.

Examination of the rectum by palpation and proctoscopy are necessary to estimate any invasion in that direction. Edema, fixation, and or hyperemia usually indicate extension of the process.

### Operative Technic

Technic of radical hysterectomy:[11] Exposure must be adequate: packing off of bowel may be accomplished efficiently with the use of moist lap packs folded and rolled to make cylinders. The anesthesia must be planned to last as long as six hours, as there is no foretelling the ease with which the procedure may be accomplished. The anesthetic of choice is a spinal, supplemented with pentothal sodium. Moderate Trendelenburg position may be of some assistance. A midline incision is usually employed, extending from the pubis to above the umbilicus. A transverse incision offers a better exposure, however, in the obese patient.

The right infundibulopelvic ligament is picked up and opened, the incision carried upward so that the ovarian vessels may be ligated high. The dissection is carried medially to the bifurcation of the aorta. This reflects the peritoneum and the ureter medially. The iliac vessels are freed of all nodes and tissue from their origin downward. The hypogastric node is usually found at the bifurcation of the iliac on the medical surface of the vein. The stripping is continued downward to expose the uterine arteries retroperitoneally. As the external iliac is dissected free of its fat and surrounding tissue, and then retracted medially, the obturator fossa is exposed. It is in this area that some of the most troublesome bleeding is often encountered from injudicious or too vigorous dissection. The obturator nerve may be used as a guide in minimizing the bleeding. Anterior to the nerve the dissection may be sweeping but once the nerve is exposed, care must be exercised. Using the small suction tip, such as used by neurosurgeons, the areolar material may be teased gently away from the underlying sacral veins and from the obturator artery and nerve as they curve over the ramus of the pubis and enter the fossa. If any of these vessels are injured, the rent in them can be identified, using the suction, and a silver brain clip applied. Packing and pressure, however, will usually stop the venous welling up of blood. The uterine vessels, having been identified, are ligated and divided. The anterior leaf of the broad ligament is opened and carried over the uterovesical fold. The round ligament is severed close to the lateral wall of the pelvis and the bladder pushed well off the vagina. Some sharp dissection in the midline may be necessary to accomplish this and expose enough cuff of vagina. The pelvic portion of the ureter must now be freed from its bed. A finger is inserted anterior to the ureter and by gently pulling anteriorly, the tissue overlying the ureter separated, exposing the ureter and its entrance into the bladder. By blunt dissection this whole structure is pushed laterally, exposing the parametrium which is then clamped as far downward as desired to give an adequate vaginal cuff.

The blood supply of the pelvic portion of the ureter has not been injured in this process as so often occurs with sharp dissection. In its course from the pelvic brim to the cervix, the ureter has been left attached to the peritoneum receiving adequate blood supply in that region. At no time is the ureter picked up with forceps or handled in any way directly. The same dissection is carried out on the left.

[10] Graham, R. M.: The Effect of Radiation on Vaginal Cells in Cervical Carcinoma, Surg., Gynec. & Obst. 84:153 (Feb.) 1947.
[11] Graham, R. M.: The Cytological Diagnosis of Carcinoma of the Cervix, Philadelphia, Saunders, 1950, p. 86.

At this point the uterus is strongly drawn upward and forward to put the peritoneum on stretch. An incision is made in the peritoneum medial to the ureter and carried medially to sever the sacro-uterine ligament. Blunt dissection will open the rectovaginal space.

The uterus is now only held by the cardinal ligaments and their extensions which surround the rectum. With the uterus and vagina on tension, these structures are clamped and severed until an adequate cuff of vagina is exposed. Curved clamps are applied across the vagina and the specimen is removed.

The clamped structures are ligated with sutures, and the cuff is closed with interrupted sutures, leaving room for drainage if that is deemed wise. Reperitonealization is done in a routine manner.

Postoperative chemical and blood balance is maintained by intravenous infusions. Ambulation is permitted early. Catheterization is first done with a self-retaining balloon catheter which is later removed; repeat catheterization is carried out after voiding until the residual is less than 100 cc.

The other radical procedure which has gained some popularity and is now being used widely is the complete or partial exenteration of Brunschwig.[12] This procedure is very similar to the radical dissection previously described, except that it is preceded by mobilization of the ureters and their implantation into the colon at or above the pelvic brim. A simple small stab incision is used for the entrance of the ureter and a wide longitudinal incision in the colon used to visualize the suturing of the ureter. The end of the ureter is fish-mouthed and a single suture of 00000 chromic used to attach these flaps to the mucosa of the colon. The rectosigmoid is divided low enough to give an adequate colostomy and the end brought out through the incision.

From this point the node dissection is the same as in the previous procedure. The bladder is completely freed from the pubis and the rectum freed posteriorly from the sacrum. When the pelvic viscera have been mobilized, the abdomen is closed. No attempt is made to peritonealize the fault.

The patient is then placed in the lithotomy position and the perineal portion of the bladder, ureter, vagina and rectum with the anus is removed by wide excision. Bleeding in this portion of the operation is no serious problem if adequate control has been executed from above. The specimen is removed from below. Six to ten laparotomy packs are placed against the unsupported bowel and most of the fault closed to leave an opening about 8 to 10 cm. in diameter.

The postoperative care of these patients requires very close supervision. As their urinary output cannot be measured, they usually represent quite a problem in fluid balance. The packs are removed at six to ten days and they are ambulated whenever it is felt that sufficient granulation tissue has developed to suspend the bowel. The fault is allowed to granulate in, taking about six weeks.

Recent revisions in this operation have reduced the size of the dissection below even to the point of leaving the external portion of the genitalia intact.

## Conclusions

1. A review of the metastatic pathways and related anatomy is presented.
2. Indications of some of the authorities are reviewed.
3. The methods of evaluating response to radiotherapy by cytological smears are shown.
4. The techniques of the radical hysterectomy with radical gland dissection and pelvic exenteration are presented briefly.

I wish to express my grateful appreciation to Dr. E. Henriksen and Dr. A. Glucksmann for their kind permission to reproduce the illustrations.

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[12] Twombley, G. H.: The Technique of Radical Hysterectomy for Carcinoma of the Cervix, Cancer 3:975 (Nov.) 1950.

[13] Racker, D. C. and Braithwaite, J. L.: The Blood Supply to the Lower End of the Ureter and its Relation to Wertheim's Hysterectomy, J. Obst. & Gynaec. Brit. Emp. 58:608 (Aug.) 1951.

[14] Brintnall, E. S. and Flocks, R. H.: En Masse "Pelvic Viscerectomy" with Ureterointestinal Anastomosis, Arch. Surg. 61:851 (Nov.) 1950.

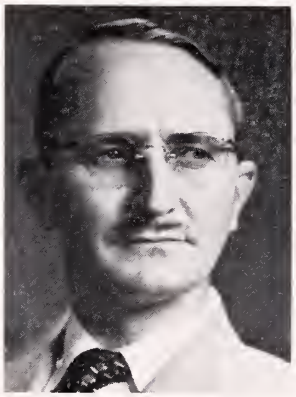
[15] Doroshow, H. S.: Electrolyte Imbalance following Bilateral Ureterosigmoidostomy, J. Urol. 65:831 (May) 1951.

[16] Brunschwig, A. and Pierce, V. K., in Meigs, J. V. & Sturgis, S. H.,[5] p. 584.

# "Primary" Glaucoma and Its Relation to General Disease

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HONOLULU



DR. PINKERTON

A PATIENT afflicted with primary glaucoma will likely be an eye problem for the remainder of his life. It behooves the ophthalmologist, therefore, to look into every conceivable ramification of the patient's general health, as it will be shown that primary glaucoma often bears intimate relationship to certain general diseases and dysfunction. To properly accomplish this he will need the help of the internist, the pathologist, the laboratory, occasionally the surgeon, and in some instances the psychiatrist. The so-called primary glaucoma may actually be secondary or an expression of a general derangement of cellular physiology and chemistry.

### General Factors

Ocular pressure is affected by the elasticity of the outer tunic (the sclera) or an alteration of the ocular contents. The ocular contents are solid (the lens, iris, ciliary body and retino-choridal tract), semi-solid (the vitreous), or liquid (blood and aqueous). The latter may affect the ocular pressure by either increased formation or obstruction to outflow.

A great variety of extraneous factors may precipitate a change in the size, function, or chemistry of the ocular contents. In some instances, these factors are influenced, and in others completely controlled, by general systemic disturbances. It is futile and at times unwise to explain the different types of glaucoma as being related to any specific structural defect of the eye, to any specific alteration in chemistry, or to any specific effect of abnormal physiology via the autonomic nervous system. Suffice it to say that the old saying that a glaucomatous eye is a sick eye in a sick body still holds a certain wide range of truth. General allergic conditions or chronic focal infection with secondary bacterial sensitivity may be the only precipitating factors to explain the glaucoma.

Read before the Sixty-second annual meeting of the Hawaii Territorial Medical Association, May 2, 1952.

It is common knowledge among those who practice ophthalmology that acute febrile diseases such as acute colds, grippe or influenza may influence the ocular tension. In predisposed eyes, acute glaucoma may be precipitated and those suffering from clinical glaucoma may become worse during such illnesses. Papillitis and retrobulbar neuritis may accompany the episode. Two cases of infantile or congenital glaucoma following maternal rubella have been reported—one with and one without a congenital cataract.[1]

Food allergy has played a role in the causation of chronic simple glaucoma, the vascular structure of the eyeball responding in a manner similar to the response of other shock organs which participate in allergic crises.[2]

Drugs, particularly the belladonna group, assume an etiologic role in glaucoma particularly when used topically, also when used orally in the treatment of gastro-intestinal disease, and when used as a preoperative medication. Internists, general practitioners and surgeons should always consider the possibility of precipitating glaucoma in all cases where belladonna or belladonna derivatives are prescribed for therapy or as preoperative medication. Ullman and Mossman[3] cite 7 cases in which glaucoma was directly related to the oral ingestion of ten drops of tincture of belladonna twice daily, or extract of belladonna, grains 0.25 taken three or four times daily. It is likely that many more cases exist. Sulfathiazole has been incriminated as having precipitated an attack of acute congestive glaucoma in a twenty-four year old woman.[4] It is likely that this was a drug sensitivity or allergic reaction rather than a mechanical effect on the motor mechanism of the pupil.

Dental, tonsil and sinus diseases are believed causative factors in certain cases of glaucoma due to inflammatory phlebostenosis of the jugular and orbital veins. Good aqueous drainage is predicated upon the fact that the venous pressure is 7-10 mm. lower in the episcleral veins than within the eyeball. Any block in venous drainage would

[1] Guerry, D., III: Congenital Glaucoma Following Maternal Rubella, Am. J. Ophth. 29:190 (Feb.) 1946.

[2] Berens, C., Girard, L., and Cummings, E.: Allergy on Glaucoma, Ann. Allergy 5:526 (Nov.) 1947.

[3] Ullman, E. and Mossman, F.: Glaucoma and Orally Administered Belladonna, Am. J. Ophth. 33:757 (May) 1950.

[4] Fritz, M. H. and Kesert, M.: Glaucoma Following Irrigation of Sulfathiazole, Am. J. Ophth. 30:197 (Feb.) 1947.

therefore disturb this pressure differential.[5] Berens and Nilson[6] reported 53 cases of chronic, simple glaucoma in which 37 showed homolateral ocular and nasal accessory sinus disease or glaucoma of greater severity on the side of the sinus infection. They believe there are toxic factors with vasomotor reactions, actual venous thromboses or allergic phenomena secondary to bacterial hypersensitivity.

Syphilis is found more frequently in those suffering from primary glaucoma than in the general populace. This is probably due to the vascular pathology incident to the disease.

Heredity has been known to play an important role. In a study of 373 unselected cases, Posner and Schlossman[7] showed 13.7 per cent had one or more relatives with the disease. It is likely that this figure is too low because sporadic cases may result from the mating of those with recessive genes. Some individuals are genetically glaucomatous, but show no clinical evidence of the disease unless subjected to some provocative situation such as dilation of pupil, cataract extraction or an emotional situation.

Climate and weather have an influence not only on the mood of man but also upon his constitution. The weather with its variability does not have a damaging effect upon the normal physiological processes, but individuals suffering from certain ailments react to such changes with exacerbation of their malady. Many studies have been done, particularly in Europe. The incidence was higher in winter, and the major portion of acute attacks occurred at the time of passage through a weather front or disturbance of some nature.

### Systemic Factors

The outstanding systemic disturbance is that of the cardiovascular system. Certain local conditions usually prevail or run concomitantly with the vascular disease. Eyes which participate markedly in the general pathological process will usually exhibit pronounced retinal and ciliary vascular sclerosis. Such vascular pathology leads to a derangement of the normal intra and extra cellular physiology. Edema of the iris, ciliary body, retina and vitreous occurs with secondary crowding of the anterior chamber angle and consequent rise of intra-ocular pressure. Prolonged, lowgrade pathology with prolonged crowding of the chamber angle results in synechia formation.

Reese[8] studied twenty-six eyes with "primary" simple, wide-angle glaucoma in which a cuticular product had obstructed the filtration angle. The cuticular membrane was produced by proliferation of the corneal endothelium. The not infrequent occurrence of choroidal, vitreous and anterior chamber hemorrhage suggests that the vascular endothelium as well as the corneal endothelium was involved. Clinical arteriosclerosis was present in 8, hypertension in 2, diabetes in 1, syphilis in 2, Parkinson's disease in 1 and spastic paraplegia in 1.

Duke-Elder[9] feels that primary glaucoma tends to occur in people just past middle age who have some vascular disability, either that of a sclerosis or a dysfunction. The first group is essentially a degenerative type and the second group is one about which little is known, but it is characterized by endothelial and vasomotor instability and is intimately connected with neurovegetative and endocrine disturbances.

Functional and organic derangements of the nervous system have long been incriminated in the pathogenesis of glaucoma. Most ophthalmologists have seen acute glaucoma crises precipitated by shock or grief. These cases respond to local therapy and require no therapy at all after the emotional crisis has terminated. These cases of course are the more obvious derangements of the nervous system. There are subclinical varieties, however, which are diagnosed with great difficulty or in whom functional derangements of the nervous system are only surmised. These cases may be detected only by pupillographic studies.[10] This is based on the existence of three phases of pupillary contraction, the initial phase being parasympathetic and the secondary and tertiary phases being sympathetic. In all cases of primary simple glaucoma there was disproportion between the primary phase and the secondary and tertiary phase. The so-called glaucomocyclitic crises which are unilateral and recurrent without much pain or ocular congestion are believed due to derangements of the hypothalamic center.

Hess[11] considers glaucoma from the standpoint of irritation of one limb of three reflex arcs:

I. Ciliary Arc. Irritation of the afferent limb is seen in those glaucomas associated with actual inflammation of the eyeball. Irritation of the efferent limb occurs in conditions when undue amounts of adrenalin are secreted. Irritation of

[5] Meyer, O.: Glaucoma Exogenicum Due to Phlebostenosis, Brit. J. Ophth. 30:682 (Nov.) 1946.

[6] Berens, C. and Nilson, E.: Etiology of Chronic Simple Glaucoma, (Possible Role of Nasal Accessory Sinus as Foci of Infection) Trans. Am. Acad. Ophth. and Otolaryngol., p. 147 (Jan.-Feb.) 1944.

[7] Posner, A. and Schlossman, A.: The Role of Inheritance in Glaucoma. Trans. Am. Acad. Ophth. and Otolaryngol., p. 145 (Oct.) 1947.

[8] Reese, A. B.: Deep-Chamber Glaucoma Due to the Formation of a Cuticular Product in the Filtration Angle, Am. J. Ophth. 27:1193 (Nov.) 1944.

[9] Duke-Elder, W.: Text Book of Ophthalmology. Vol. III, C. V. Mosby Co., St. Louis. Mo., 1941, p. 3339.

[10] Lowenstein, O. and Schoenberg, M. J.: Nervous Factor in the Origin of Simple Glaucoma, Arch. Ophth. 31:384 (May) 1944.

[11] Hess, L.: Pathogenesis of Glaucoma, Arch. Ophth. 33:392 (May) 1945.

the central portion of the arc may occur in the glaucoma of herpes zoster.

II. Diencephalic Arc.

III. Cortical Reflex Arc which acts by virtue of the cortico-thalamic fibers which mediate the nerve impulses from the cortex to the sub-thalamic centers. It is clear that derangements of the autonomic nervous system and disturbances of the higher cortical levels of the nervous system are important as precipitating or, at least, participating factors in various glaucomatous states.

Disturbance of endocrine physiology may play a definite role in the pathogenesis of glaucoma through its effect upon the autonomic nervous system. Physicians and general practitioners should pay more attention to ocular studies in those patients manifesting endocrine dysfunction, particularly the hyperthyroid cases, and particularly if the patient is in the glaucoma age group.

Diabetes is frequently found in association with primary glaucoma. It is very likely a factor by virtue of the accompanying vascular sclerosis associated with diabetes of long duration. It is occasionally a factor in those secondary types associated with acute edema of the lens.

Jeandelize, P.[12] observed five cases of primary juvenile glaucoma in whom hypo-pituitarism was present. All responded to injections of posterior pituitary extract. Hypoglycemia was present and it was believed that the pituitary extract improved the glaucoma by its effect upon the blood sugar.

The gonads are thought to influence the ocular pressure but these observations and experiments are far from conclusive. Scobee[13] noted that in 1300 inmates of a state training school for feebleminded, all of whom had been castrated, the incidence of glaucoma was exceptionally low although over half were in the glaucoma age group. Ulcer incidence was likewise very low.

Radnot,[14] experimenting with male rabbits showed that castration caused a temporary fall of ocular tension.

The above findings, however, do not tie in with the fact that primary glaucoma usually occurs at a time in life when gonadal function is decreasing.

Presented herewith are tables showing the results of a study of 100 cases of primary glaucoma taken from the files of The Queen's Hospital. Most of the cases required surgery of one type or another. Many terminated in total blindness. Complete work-up was very inadequate on many.

[12] Jeandelize, P.: Hypopituitarism in Primary Juvenile Glaucoma, Ophthalmologica 118:548 (Oct.-Nov.) 1949.

[13] Scobee, R. G.: The Eyes in Feeble Minded Castrates, Am. J. Ophth. 26:1289 (Dec.) 1943.

[14] Radnot, M.: Male Gonads and Intraocular Pressure, Ophthalmologica 107:282 (May-June) 1944.

100 Cases of PRIMARY GLAUCOMA by Nationality

| CAUC. | JAP. | CHI. | HAW. | PORT. | FIL. | KOREAN | NEGRO |
|---|---|---|---|---|---|---|---|
| 38 | 20 | 10 | 10 | 9 | 9 | 2 | 2 |

Conclusion: Of the cases studied, primary glaucoma is well distributed. Caucasians predominate and exceed their percentage per capita population. Japanese are below in percentage involved per capita of population. The incidence in Hawaiians is significantly higher than the 2.8% of Hawaiian population. The above average incidence per capita in Chinese is probably not significant.

100 Cases of PRIMARY GLAUCOMA (Sex Incidence)

| | MALE | FEMALE |
|---|---|---|
| Chronic Glaucoma | 37 | 34 |
| Acute Glaucoma | 9 | 19 |
| So-called Glaucoma Cyclitic Crisis | 1 | .... |

Conclusion: Sex distribution seems about equal for chronic types. More women manifest acute phases of the disease. However, they are probably well established chronic conditions at the time of the acute episode. If this is true, the disease would appear to be slightly more common in women—in the series studied.

100 Cases of PRIMARY GLAUCOMA
(Incidence of other conditions)

| HYPERTENSIVE VASCULAR DISEASE | HVD WITH RENAL MANIFESTATIONS | DIABETES MELLITUS | POSITIVE SEROLOGY (SEROLOGY RECORD NOT AVAILABLE IN OVER HALF OF 100 CASES) |
|---|---|---|---|
| 43 | 20 | 9 | 7 |

| DUODENAL ULCER (ACTIVE) | DURING ACUTE RESPIRATORY INFECTION | POST-OPERATIVE (ABDOMINAL) | DURING CORONARY ATTACK | ACTIVE ALLERGIC DISEASE |
|---|---|---|---|---|
| 2 | 3 (acute attack) | 2 | 1 | 4 (1 during attack of acute urticaria) |

Conclusion: Hypertensive cardiovascular disease is outstanding in its relation to primary glaucoma. There is a definite association with diabetes and syphilis, but probably due to the vascular damage known to occur in these diseases. The association with ulcers is probably on a vascular basis related to disturbance of the autonomic system. Respiratory infections may hinder the venous drainage from the head region, thus promoting the increased ocular pressure. The postoperative occurrence of glaucoma may be insignificant, but might have been related to emotional shock or use of atropine preoperatively in a patient predisposed to glaucoma.

## Summary

Primary glaucoma has been considered briefly from the standpoint of its relation to febrile disease, foods, drugs, focal infection, heredity, climatic conditions, and its relation to pathology of the cardiovascular system, nervous system and endocrine system.

## Conclusion

All cases of primary glaucoma should be carefully studied and evaluated from the standpoint of the body as a whole, particularly the vascular and autonomic systems, and should not be considered as an isolated condition confined to the eyeball.

Young Hotel Building

# Management of Male Infertility Problems

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THE management of male infertility problems is still not based on a completely scientific foundation. Neither is it any longer shot-gun therapy. Since the end of World War II there has been a tremendous impetus toward accumulating information about semen and general male physiology in relation to infertility. We are now aware of a few basic causes of infertility and by deduction we can imply other causes. We have not, however, a completely satisfactory regimen for curing infertility.

What is offered now about managing male infertility does not include those cases infertile because of obstructive lesions of the seminal tract. Scarring of the epididymides resulting from gonorrheal, or other bacterial, epididymo-orchitis is rarely amenable to surgical repair, as are those cases with congenitally absent epididymis or vas deferens. On the other hand, re-anastomosis of the vas deferens following vasectomy is probably 75 per cent successful. We are not concerned at present with sterility due to failure of descent of the testes, to mumps orchitis, to atrophy of the germinal epithelium from irradiation, or to traumatic atrophy of the testicles. These problems are not of primary importance to us now, and they actually involve only 5 per cent of the cases of male infertility.

The major problem with which we are concerned involves those deficiencies of the male reproductive tract leading to oligospermia or aberrations of the sperm or seminal fluid. Ninety-five per cent of the infertility problems fall within this category.

## Semen Analysis

To successfully handle the young man whose marriage is childless or whose wife has had repeated abortions due to faulty semen, one must first analyze that young man's physical status and semen. A careful analysis of semen is essential before one can determine any treatment. It is imperative to have a reliable technician whom you have carefully trained to evaluate semen. Better yet, examine the semen yourself. The counting of sperm is a purely mechanical job, as is the estimation of motility, but the morphological evaluation of sperm requires time and concentrated study of the specimen. The accompanying chart, which is the type used by the author, is offered as a guide post and record of your semen analysis.

Semen quality may be divided into four categories: sperm count, sperm motility, sperm morphological appearance, and seminal fluid characteristics. This latter category includes ejaculate volume, pH, consistency, and the rather vague thigmotropic factor. Part of the management of infertility problems lies in the knowledge of the variations within each of these categories.

SEMEN ANALYSIS

Masturbated ..... Time ejaculated .....
Condom ..... Time received in Laboratory .....
Post Coital ..... Time of previous ejaculation .....
Weight ..... Mucolysis complete ..... Incomplete .....
Volume ..... Time required for mucolysis .....
Ph ..... Opaque ..... Clear ..... Viscosity .....
Count per ml ..... Count total spec .....

Morphology:

| | | |
|---|---|---|
| Normal forms | Bent body | Bacteria |
| Pyriform | Abnormal Acrosome | R.B.C. |
| Round Heads | Immature forms | W.B.C. |
| Megalosperm | Double tail | Epith. cells |
| Microsperm | Double head | Crystals |
| Curled tail | | |

Motility:

| | | | | |
|---|---|---|---|---|
| Time | | | | |
| Swift | | | | |
| Moderate | | | | |
| Sluggish | | | | |
| Motionless | | | | |

Remarks: .....

.....

### *Sperm Count*

The American Society for the Study of Sterility has advised that the arbitrary figure of 60 million sperm per cc. of semen be considered the lowest concentration compatible with fertility. However, most urologists who concentrate on infertility problems feel that 20 million sperm per cc. is a more accurate standard, provided other seminal factors are normal. This has been well substantiated by John MacLoed,[1] working at the Cornell-

From the Department of Urology, University of Southern California School of Medicine.

Read before the Honolulu Academy of General Practice July 8, 1952.

[1] MacLoed, J.: Certain Concepts in Human Male Fertility, J. Urol. 67:19 (Jan.) 1952.

New York Hospital Sterility Clinic, who has based his opinion on the statistical analysis of two thousand semen examinations including both fertile and sub-fertile men.

*Motility*

From 80 to 85 per cent of the sperm should be actively motile immediately after ejaculation and a significant portion of these should remain motile for at least six hours. In an uncontaminated container and at room temperature about 20 per cent of these sperm will remain viable and motile for twenty-four hours or longer.

*Morphology*

Out of every 100 individual sperm which are examined for morphological appearance at least 80 to 85 should appear normal. Double-tailed, or two-headed monster sperm, or giant sperm, are frequently seen and conceivably are just as likely to fertilize the ovum as are the normal sperm. I have a very strong personal conviction that these abnormal sperm are an important factor in producing repeated abortions. Abnormality in the morphological appearance of the sperm has been the most consistent seminal deficiency factor among the husbands whose wives have had more than one abortion. Likewise, improvement in the morphology by treatment has led to less frequent abortions.

*Seminal Fluid*

Much stress has been laid on the importance of the pH by the original investigators of the seminal fluid. This is no longer a factor for consideration. Of the hundreds of semen specimens examined by the author there has never been one that was not in the alkaline pH range of seven or eight. If a specimen were found with an acid pH it could be an indication of contamination with urine or disease of the seminal vesicles or prostate.

The seminal fluid should change from the tenacious, thick material that is normal at the time of ejaculation to a relatively fluid state of homogeneous consistency and opacity in about thirty minutes. Failure of this mucolysis to take place is indicative of a seminal fluid deficiency. In view of all the investigation about sperm themselves there is a relative dearth of information about the role of the seminal fluid in problems of infertility. In the author's opinion, the lack of complete mucolysis of seminal fluid is a contributing factor in the sub-fertile man. Some physiological imbalance within the seminal vesicles or prostate, or both, is no doubt the basis for this aberration.

Included in your evaluation of seminal fluid must be a search for crystals. This must be done immediately after ejaculation, during your first check on motility, because all semen will form crystals after standing for several hours. Crystallospermia is indicative of an abnormal chemical balance between the sugars and salts in seminal fluid. It is probably a function of an abnormal seminal vesicle and is usually associated with poor motility and short-lived sperm. If your examination reveals crystals in semen immediately after ejaculation I feel that you are justified then and there to say that the specimen is infertile.

Of equal importance but of less frequent occurrence is the thigmotropism of sperm noted in infertile semen. Sperm, of course, are normally thigmotropic for other cell bodies. We have all seen them clustering about pus cells in the semen, and their thigmotropic tendency is necessary for invading the ovum. They are not, however, normally thigmotropic for each other. This tendency of the sperm to agglutinate together with their heads in a huddle and their tails waving in the breeze most naturally decreases their ability to migrate toward the ovum.

These three subjects that have just been discussed, thigmotropism, crystallospermia, and incomplete mucolysis, are the three most important contributing factors to infertile semen due to seminal fluid deficiency. We can neglect, at the moment, ejaculate volume as an important factor in seminal fluid deficiencies except to say that extremely high volumes are usually associated with the most infertile men.

To complete our analysis of semen we must correlate the results of our findings in each of the above categories for practical application.

*As a rough standard on which we might base our needs for treatment of a given case of questionable fertility let us use twenty million sperm per cc. as the border-line between sub-fertile semen and fertile semen. The degree of fertility, then, will vary proportionately with the percentage of normal sperm and their motility, providing no aberration of the seminal fluid exists.*

The words "rough standard" have been used in describing this rule-of-thumb for determining fertility because no precise, mathematical formula can be applied to any subject as relative as fertility. The patient sitting in front of you might be a relatively infertile man married to a relatively infertile woman and they will never conceive. Yet, either one of them with a highly fertile partner might breed a whole string of income tax deductions. Many times, in spite of all the

careful thought you have given the problem, you may come to the conclusion that you just do not know whether the patient is fertile or not.

This man whose fertility you question, as well as the man whom you found infertile by applying your "rough standard," should be treated. It does not matter particularly in which category of semen quality he is deficient. The treatment is basically the same because we are dealing with faulty spermatogenesis in general, though the specific deficiency may be limited to poor motility only or poor morphology only.

You will find many men who have such poor semen quality that no matter what you do they will never become fertile. No one knows the specific borderline of semen quality below which is the "point of no return." The range of this borderline is probably tremendous and a matter of individual variation. As an example, if a semen consistently contains only a million sperm in the entire specimen you should consider the man hopelessly infertile and tell him so, as it would be useless to encourage this man by treating him.

### Treatment

The first approach to treatment of infertility problems was with thyroid. This medication alone proved successful in many instances where only a minor deficiency of the semen existed and where the man happened to have a lagging metabolism. It was with good logic that thyroid was first used because we consider the thyroid gland as one of the master glands with definite influence on the gonads.

Endocrine therapy, then, became established and led, logically, to the use of testosterone and pituitary gonadotropins when these substances were made available for clinical use.

More recently, knowledge about the endocrine tie-up of the liver with the pituitary and gonads has added another endocrine drug, namely liver, to the old group. The liver probably plays a major role in controlling the balance of the androgens and estrogens in the male body. It does not do this by stimulating secretion of these hormones but by destroying the circulating hormones proportionately to maintain a balance. Chronic liver damage from disease or malnutrition then, is apt to cause a gonadal dysfunction. On this basis, *whole liver, high protein intake* and *vitamin B complex* have become members of the team to combat infertility.[2]

[2] Glass, S. J., and Russell, M.: Improved Spermatogenesis after a Nutritional-Liver Regimen with and without Testosterone, Fertility and Sterility 3:167 (Mar.-Apr.) 1952.

Another member of the team is *vitamin A.* We know that the germinal epithelium of the testicle is faulty when infertility exists. When we speak of the faulty germinal epithelium we are getting down to the root of the infertility problem, for, at present, what lies behind this faulty epithelium is still conjecture. Nevertheless, the role of vitamin A on the health of all types of epithelium is accepted; so this vitamin must play a part in our treatment. We have mentioned the principal substances used in treating infertility but how to use them is even more important.

*Thyroid* should be given in small doses to all infertile men who have a normal or low basal metabolic rate. Thyroid is empirical in the treatment of these problems but, of course, it is not indicated in those men with an elevated metabolism. In many borderline infertility cases thyroid alone may bring about a significant improvement in motility and morphology. It is doubtful if it will have much effect on the sperm count per se.

The *pituitary gonadotropins* were a fad several years back. Based mainly on claims by the manufacturers, these drugs were touted as the complete answer to infertility problems. This is not true. Except in an occasional instance, the pituitary gonadotropins are of little benefit. In fact, in a significant number of cases you will find the semen becomes even worse after treatment with these substances. However, one exception may be in the middle-aged man who has become infertile. Patients in this age range are infrequent, of course, but there is some clinical evidence to indicate that these men may respond successfully to pituitary gonadotropins. The place for pituitary gonadotropin therapy lies principally in those cases who demonstrate an actual deficiency of this hormone in their bodies as determined by urine hormone assay.

*Testosterone* has been used in an extreme range of dosage schedules with varying results for years. The knowledge that prolonged administration of this androgen produces inhibition of testicular function discouraged enthusiasm for it. Yet this very factor of testicular depression is the basis for the dramatic results obtained by Heller[3] in treating sub-fertile men. He advises large, unphysiological doses of testosterone, in the range of 25 to 100 milligrams daily for up to three months. This produces complete suppression of testicular function. When the hormone is stopped he has

[3] Heller, C. G. et al.: Improvements in Spermatogenesis following Depression of the Human Testis with Testosterone, Fertility and Sterility 1:415 (Sept.) 1950.
Heller, C. G. et al.: The Effect of Testosterone Administration upon the Human Testis, J. of Clin. Endocrinology 10:816 abstract (July) 1950.

found that the testicular function not only returns to its former level but usually surpasses previous function. His results are very gratifying to hear about, but no one can be *definitely* sure the testicular function *will return.* Heller assures us that it will, but that we must often wait one and a half to two years for results. The author's experience with Heller's routine has been limited and applied only to those cases considered otherwise hopeless, and it has been completely unsuccessful. Testosterone, however, given in small doses for short periods of time is a temporary stimulant to spermatogenesis. The endocrine and nutritional tools which have been mentioned play a role as well in the health of the accessory organs of sex, the seminal vesicles and prostate. In addition, however, it is occasionally necessary to massage the prostate and strip the vesicles to enhance their ability to create normal seminal fluid.

Pus in the semen, in itself, does not mean the man is infertile, but it indicates a low-grade inflammatory process. If this inflammatory process is cleaned up it stands to reason that the accessory organs can function more normally.

### Treatment Plan

At the risk of being too dogmatic the following scheme for treatment of infertility problems is proposed:

*Thyroid*: Grains 1 to 2 daily in divided doses morning and evening, provided the basal metabolic rate is not elevated.

*Vitamin A*: 100,000 units daily; in 50,000 unit capsules taken twice daily.

*Brewer's Yeast*: This is preferable, along with liver, as the source of the B complex vitamins because it is a natural form. Approximately 30 grams daily are indicated. The powdered form is preferable to the tablet.

*Liver*: Each capsule containing one-half gram of whole, dried liver. Prescribe two capsules after each meal.

*Protein*: Careful instruction of the patient on what a high protein diet is will usually suffice, but it should run to about two grams of protein per kilogram of body weight per day.

*Testosterone*: Depending upon the degree of infertility and your findings on follow-up semen examinations you may want to boost your therapy along with testosterone. It is advisable to give 50 milligram injections twice or thrice weekly for a total of 500 milligrams. Then *stop,* and *wait* at least six months before another booster course of testosterone.

*Gonadotropins*: If your judgment dictates the use of these pituitary substances it is recommended that you do so on a schedule similar to that for testosterone. There is no sound reason for using *both* the gonadotropins and testosterone. Daily injections of the pituitary substances for three to four weeks followed by a rest period of six months may help the cause.

*Heller Routine*: Again if your judgment dictates that you need a drastic therapeutic effort you can use the Heller Routine. It is advisable that this be reserved for those cases with such poor semen quality that they are apparently lost causes, or those cases completely resistant to the plan already outlined.

This routine consists of daily doses of 25 to 100 milligrams of testosterone for up to three months. According to Heller this plan cannot be considered a failure until two years have gone by after the course of treatment. It would be wise to maintain your patient on the thyroid-liver nutritional regimen during this long testicular rejuvenation period.

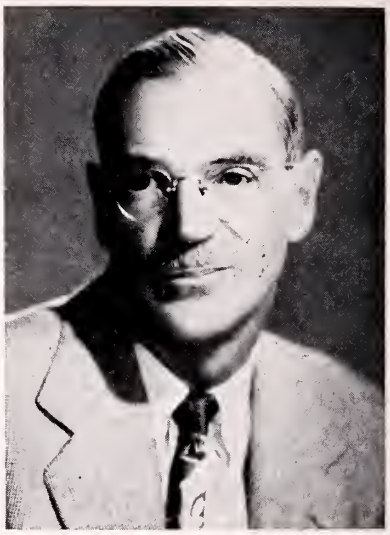
### Conclusion

In conclusion, let me again emphasize the need for a careful semen evaluation, from which you can determine the degree of fertility by using the proposed "rough standard."

Your treatment of the infertile man, then, should include those substances, endocrine and nutritional, that will provide an effective physiological stimulus to spermatogenesis.

Do not get discouraged by the length of time it takes for results with these men, and, above all, dot not let the patient get discouraged with treatment. At the same time do not be too optimistic, because the overall picture of infertility still weighs heavily on the pessimistic side.

9730 Wilshire Boulevard.



# *The President's Page*

## MEDICAL ECONOMICS

I have been aware for sometime of a certain personal trait in some people that is neither commendable nor easy to deal with.

An occasional patient, after running up a considerable medical bill, may become embarrassed to ask for further medical care. The patient contacts a new doctor. Not wishing for the reason for change to be generally appreciated, the patient begins to undermine the first doctor in any way possible in order to mask the real reason. There is little the doctor can do but take it on the chin.

Suppose a patient, though able to pay for services, does not change physicians and more stern methods are used to collect such a bill. Too often the doctor loses the patient together with many good potential patients who do pay for services rendered but are friends of the original one.

The physician is damned if he does and damned if he doesn't. He is damned if he allows a bill to run up and he is damned if he tries to collect either through stern measures himself or through a collection agency.

Personally I believe these economic problems can be solved if all doctors and dentists combine to act as a group. A committee on Medical Economics could study a plan to present to the Delegates at the coming Annual Meeting. This committee, after study, might make recommendations on the following:

1. How old should an account be before it is turned over to an agency chosen by the Territorial Association?

2. What agency to handle accounts would the committee suggest? Could we have our own?

3. Any further suggestions on the problem of collection of medical accounts.

Such an organized attack would take the stigma from the doctor or dentist. A patient may be told, "All the Association has agreed to turn certain accounts over to an agency. We feel it our duty to cooperate with our own Society. It takes this business burden off our hands and allows us to spend more of our time with the practice of medicine. If this organization is unduly pressing you, please come to see me and I will try to make some adjustments that may help you."

All the doctors are equally involved. The doctors have control of the agency chosen. In line with an ever-increasing need—the doctors are making another move to *run their own business.*



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# [EDITORIALS]

## NEVER MIND THE PATIENT WHAT ABOUT HIS FAMILY?

We have recently observed with pleasure that the growing modern tendency to be interested in the group as a whole, rather than in the individual, has led the United Nations into a minor absurdity.

The Medical History portion of the physical examination form of the Food and Agriculture Organization of the United Nations (Adm. Form 151A, 4-51-3M) inquires whether any of the individual's relatives have had, or now have, tuberculosis, cancer, diabetes, epilepsy or insanity.

It seems reasonable to suppose that the interest in the family incidence of cancer is based on the greater risk of occurrence of cancer in the individual from a family with cancer, than in the individual without such a background.

Yet in a list of 19 diseases or categories of diseases which the patient is requested to state he has either not had, or had (and if so, when) no mention is made of cancer. The other inquiries about the family are repeated in this list—but not cancer.

This is undoubtedly an oversight—but we wonder whether a psychiatrist would not find in it a symptom of more interest in groups than in individuals. We like to think that this may be the case, anyway.

## ERYTHROMYCIN: IMPORTANT NEW ANTIBIOTIC

Erythromycin, discovered and crystallized in the Lilly laboratories and marketed by them under their trade name Ilotycin and by Abbott as Erythrocin, is an antibiotic produced by Streptomyces erythreus, an organism isolated from a soil sample obtained in the Philippines.

Given only by mouth, in doses of 3 to 5 100-mg. enteric-coated tablets every six hours, the drug appears to be effective in general against the gram-positive bacteria (hemolytic and some non-hemolytic streptococci, pneumococci, and staphylococci). Its effectiveness in gonorrhea is doubtful.

Reactions to date have been limited to nausea, vomiting and diarrhea in patients receiving 600 to 1000 mg. every six hours. Erythromycin does not radically alter the intestinal flora, and the enteritis occasionally seen after administration of the other broad-spectrum "-mycins" has not been seen following its use.

Principal use of erythromycin at the present time is against organisms resistant to other antibiotics, and in patients hypersensitive to other antibiotics. There is not enough evidence yet to justify naming erythromycin the antibiotic of first choice in any infection. But it is a highly promising new member of the antibiotic team.

## THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

### YOUR LOCAL CHAPTER

The National Foundation for Infantile Paralysis reaches every community in the Territory of Hawaii through its local Chapters on the Islands of Hawaii, Kauai, Maui and Oahu.

Chapter members are local citizens who perform many hours of volunteer service. Their responsibility is to see that every poliomyelitis

patient — man, woman or child — receives good care. Using March of Dimes funds raised locally, they pay all or part of the cost of care that a patient or his family cannot afford without undue strain on the family budget.

Since the care of infantile paralysis patients is the major concern, each Chapter is advised and guided in its patient-care program by a medical advisory committee composed of members whose professional skills equip them to counsel the Chapter on all problems connected with medical care. Advisory committee membership includes representatives from the fields of general practice, orthopedics, pediatrics, neurology, public health, hospital administration, nursing, and physical therapy. Primary functions of the committee are:

1. To serve as a link between the Chapter and professional personnel, such as the Medical Society, Health Department, Nursing Association, hospitals, interpreting Chapter services to poliomyelitis patients.
2. To assist in establishing with the treatment center procedures which will be uniformly acceptable to the attending staff for the admission, treatment and discharge of poliomyelitis patients.
3. To recommend to the Chapter standards of service for which monies may be spent by the Chapter in the event the poliomyelitis patient or his parents require financial assistance from the Chapter for the payment of services.
4. To recommend to the Chapter purchase of equipment which is needed by the treatment center for the care of poliomyelitis patients.
5. To establish a schedule for the payment by the Chapter of medical fees if the physicians in the community are accepting payment from a voluntary public agency for professional services.
6. To serve as a "grievance committee" when there are disagreements between the Chapter and an individual physician regarding professional fees or other practices which may not conform to the established procedures for treatment as referred to above.
7. To recommend fields in which the Chapter might award scholarships for advanced professional training.
8. To recommend projects which the Chapter might underwrite or sponsor for the benefit of medical and professional groups.

A National Foundation Chapter does not employ physicians, nurses, physical therapists or other professional workers, nor does it operate treatment centers. The Chapter's patient-care program is carried on through existing facilities, in cooperation with public and private agencies, hospitals, and professional groups. The Chapter may provide funds for employment by an existing center of professional personnel necessary to the good care of poliomyelitis patients.

The treatment of every patient with poliomyelitis rests solely in the hands of his physician. In no instance may a Chapter interfere with the medical care or disturb the physician-patient relationship. It is the job of the Chapter to AID the physician in charge—by making available to him funds, material or consultative services, as he desires them, to insure the maximum recovery and return to health of his patient.

The National Foundation Chapters in the Territory deeply appreciate the interest and cooperation which they have received from local physicians and wish to re-state their desire to render any assistance possible toward the establishment of satisfactory services for poliomyelitis patients.

RICHARD S. DODGE, M.D., *Chairman*
Professional Advisory Committee
Honolulu Chapter, N.F.I.P.



# THIS IS WHAT'S NEW!

**Intravenous trypsin** may prove to be the biggest therapeutic advance since ACTH and Cortisone. There is evidence that in animals the intravenous infusion of trypsin is capable of **dissolving artificially induced thrombi.** (Innerfield, et al., *J. Clin. Invest.* 31:1049 [Dec.] 1952.) Clinical investigation with "Enzar," (purified crystallin trypsin, Armour) is in progress in several medical centers.

**Atherosclerosis** and high plasma cholesterol produced in chickens by a high-fat, high-cholesterol diet can be prevented by the simultaneous feeding of **dihydrocholesterol.** (Siperstein, et al., *Circulation* 7:37 [Jan.] 1953.) The only trouble is that the ratio of dihydro— to regular cholesterol in this experiment was 2 to 1. If smaller amounts of dihydrocholesterol prove effective, it may be a more practical, pleasant method in the prevention and treatment of atherosclerosis than the present low-fat, low-cholesterol diets.

**Pryidoxine** (100 mg.) added to Mercuhydrin is reported to restore diuretic response in edematous cardiac patients who have developed **"mercurial fastness."** One must first be sure, of course, that the patient is not suffering from salt depletion (low serum sodium; correctable with Na Cl), or the hypochloremic alkalosis which may result from prolonged mercurial therapy (low serum potassium, low $CO_2$; correctable with $NH_4Cl$). (Waldman and Pelner, *Am. J. Med. Sc.* 225:39 [Jan.] 1953.)

**Prantal,** an anticholinergic drug introduced for the treatment of peptic ulcer, has been put to a new use by Vickers. He found 10 to 15 mg. (IM) produced "dramatic" relief of **acute bronchial asthma.** In status asthmaticus this dosage was ineffectual. (*J. Maine Med. Assoc.* 43:381 [Dec.] 1952.)

**Atabrine** has a new use too: a trio of articles in the *Journal of Investigative Dermatology* (Dec. 1952) describes impressive results in the treatment of chronic discoid **lupus eythematosus.**

**Balarsen,** a trivalent arsenical, was found to cure 23 of 25 cases of **amebiasis** treated by Levy and Talley, after a single 5 day course (1 gram/day, orally). Follow-up was unusually good in this series, and the relapse rate was only 10 per cent in one year. (*Gastroenterol.* 22:588 [Dec.] 1952.)

Trend is toward **smaller doses of ACTH intravenously** rather than IM in the treatment of allergic conditions. Hampton (*J. Allergy* 23:493 [Nov.] 1952) found 10 mg. of ACTH intravenously more prompt, effective and economical than the usual IM doses, in the management of bronchial asthma, urticaria, and allergic dermatitis. He wonders about the possible effectiveness of even smaller doses, 5 mg. or even 1 mg. (Why give any? Why not just some lomi-lomi over the adrenals?)

**Prophylaxis of rheumatic fever** with penicillin seems to be on firm footing. The oral doses required, however, are large and somewhat expensive. A new approach to the problem is described by Stollerman et al (*JAMA* 150:1571 [Dec. 20] 1952) in the form of a new repository penicillin, **"Bicillin"** which in doses of 1.2 million units IM gave a therapeutic blood level (0.03 units/ml.) in 90 per cent of children for *three weeks,* and in 70 per cent of children for *four weeks.*

TACE (**trichloroanisene,** Merrell), a new synthetic estrogen, is most useful in palliative treatment of **prostatic carcinoma,** since it seldom produces gynecomastia. Combination of Tace and cortisone occasionally induces a remarkable remission of the pain due to metastases.

Another treatment for prostatic carcinoma, direct injection of **radioactive gold** into the prostate (via suprapubic cystotomy) followed in three weeks by transurethral resection, is producing incredibly good results in a large unpublished series of cases. Rationale: the radiogold is deposited in subcapsular area and burns out the rim of carcinoma which is so difficult to scoop out with the resectoscope.

**"Small bladder" symptoms** (frequency, urgency and decreased capacity of the bladder) were relieved in 12 patients with assorted diagnoses (Hunner's ulcer, trigonitis, etc.) by **Banthine** 100 mg. q.i.d., quoth Riskin and Zide. (*J. Urology* 68:636 [Sept.] 1952.)

(Our) Skepticism Unlimited: Campbell and Pruitt (U. S. Army) treated patients with **viral hepatitis** (3 groups of 100 each) with: (I) bed rest and diet; (II) same as I, plus multivitamins and brewer's yeast; (III) same as I, plus 30 micrograms of vitamin $B_{12}$ *by mouth* for 5 days. Claims: patients with $B_{12}$ had more rapid return of normal appetite, normal liver size, normal serum bilirubin. (*Am. J. Med. Sci.* 224:252 [Sept.] 1952.)

C. A. Domzalski, Jr., M.D.

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## Recent Acquisitions

**Biography**

Lambert, S. M. *A Yankee doctor in paradise.* c1941. (gift of Dr. Judd).

McKie, Douglas. *Antoine Lavoisier.* c1952. (gift of publisher).

**Cancer**

Armed Forces Institute of Pathology. *Atlas of tumor pathology.* Sec. III, Fasc. 9; Sec. IV, Fasc. 16; Sec. V, Fasc. 18; Sec. IX, Fasc. 34. c1950-51. (gift of Armed Forces Institute of Pathology).

Kaehele, Edna. *Living with cancer.* c1952. (gift of publisher).

**Dietetics**

Bayer, L. M. *Kitchen strategy.* c1952. (gift of publisher).

Clark, G. W. *A vitamin digest.* c1952. (gift of publisher).

**Drugs**

Adriani, John. *The pharmacology of anesthetic drugs.* 3rd ed. rev. c1952. (gift of publisher).

Waksman, S. A. *The literature on streptomycin. 1944-1952.* c1952. (gift of publisher).

Wikler, Abraham. *Opiate addiction.* c1952. (gift of publisher).

**Gynecology and Obstetrics**

American Congress of Obstetrics and Gynecology. *Transactions . . . 5th American Congress . . . 1952.* c1952. (gift of publisher).

Novak, Emil. *Gynecologic and obstetric pathology.* c1953.

**Hematology**

Flynn, J. E., ed. *Blood clotting and allied problems. Transactions . . . 5th conf., Jan. 21/22, 1952.* c1952. (gift of Josiah Macy, Jr. Foundation).

Holden, W. D. *Acute peripheral arterial occlusion.* c1952. (gift of publisher).

Wall, R. L. *Practical blood grouping methods.* c1952. (gift of publisher).

**Medicine**

Conybeare, Sir John, ed. *Textbook of medicine.* 10th ed. 1952. (gift of Brother Cummingsmith).

Geikie-Cobb, Ivo. *A guide to medicine.* 1951. (gift of Brother Cummingsmith).

Reifenstein, E. C., Jr., ed. *Metabolic interrelations. Transactions . . . 4th conf., Jan. 7/8, 1952.* c1952. (gift of Josiah Macy, Jr. Foundation).

**Neurology and Psychiatry**

Abramson, H. A., ed. *Problems of consciousness. Transactions . . . 3rd conf., March 10/11, 1952.* c1952. (gift of Josiah Macy, Jr. Foundation).

Bellak, Leopold, ed. *Psychology of physical illness.* c1952. (gift of publisher).

McCullough, W. S. *Finality and form.* c1952. (gift of publisher).

Slavson, S. R. *Child psychotherapy.* c1952. (gift of publisher).

**Ophthalmology**

Linksz, Arthur. *Physiology of the eye . . . Vision.* v.2. c1952. (gift of publisher).

Von Tschermak-Seysenegg, Arnim. *Introduction to physiological optics.* c1952. (gift of publisher).

Wiener, Meyer. *Surgery of the eye.* 3rd ed. rev. c1952. (gift of publisher).

**Orthopedics**

Shands, A. R. *Handbook of orthopaedic surgery.* 4th ed. c1952. (gift of publisher).

**Poliomyelitis**

International Poliomyelitis Congress. *Poliomyelitis papers and discussions presented at the Second Poliomyelitis Conference.* c1951. (gift of National Foundation for Infantile Paralysis).

**Miscellaneous**

Dorland, W. A. N. *The American illustrated medical dictionary.* 22nd ed. c1951.

Quarterly cumulative index medicus. v.49. Jan.-June, 1951.

Russell, P. F. *Malaria.* 1952. (gift of publisher).

* * *

We wish to acknowledge with thanks the generous contribution of $350.00 from the Cancer Society. With this help we will be able to buy forthcoming books which are important in the field of cancer research, and also cover a few journal subscriptions. Since the literature in many other fields, such as pathology and roentgenology, is largely devoted to problems relating to cancer, we are particularly grateful for the aid of the Society in enabling us to give our local doctors, nurses and research workers the materials they need for their study of this all-embracing problem.

* * *

All users of the Library will welcome the news that the Board of Medical Examiners has approved the expenditure of $1,500.00 for purchase of additional books for their collection. The original grant from the Board was made in 1951, for books and shelving. Their purpose in establishing this collection was to aid doctors studying for their examinations, but it was also to be available to all borrowers. These books are in the Library alcove, and most of them are recent texts representative of every field of medicine. The collection has been well used during the past year, and will be even more valuable when new titles are purchased and added to the present holdings.

# BOOK REVIEWS

## Opiate Addiction.

By Abraham Wikler, M.D., 72 pp., Price $3.00, Charles C. Thomas, 1952.

Dr. Wikler is one of the most qualified physicians in the world today to discuss this subject. His training and experience includes extensive work in the field of neurology, neurophysiology, psychiatry and experimental methods in general. I know him personally and have worked with him and know that he is "specialist qualified" in each of these fields. His workshop has been the wards and the Department of Experimental Neurophysiology at the U. S. Public Health Service Hospital at Lexington, Kentucky. Since the Federal Government decided to investigate this problem several years ago, no expense has been spared in providing excellent laboratory equipment, animals and human clinical material for investigative purposes.

Dr. Wikler has summarized a modern concept of the nature of opium addiction in a concise, straight-forward manner. The book is easy to read. His material is presented clearly so that his clinical and experimental evidence is well-evaluated and excellently summarized.

In my opinion, this monograph contains the most valid and useful information on the subject of opium addiction available today and I would recommend it to every physician who is interested in a 1952 evaluation of the problem.

V. C. WAITE, M.D.

## Psychology of Physical Illness.

Edited by Leopold Bellak, M.D., 243 pp., Price $5.50, Grune & Stratton, Inc. 1952.

This deceptively thin volume is a readable symposium of the psychiatric aspects of the various medical and surgical specialties. Description and dynamics are excellently presented, but practical, therapeutic assistance to the physician who is faced with psychosomatic problems in daily practice is characteristically lacking.

Specialists and general practitioners alike will find the chapter devoted to "The Personality of the Physician as a Factor in Healing" well worth reading. The few additional minutes invested in scanning the chapters devoted to their particular interests should prove rewarding.

WILLIAM H. STEVENS, M.D.

## The Literature on Streptomycin 1944-1952.

By Selman A. Waksman, Revised Edition, 553 pp., Price $5.00, Rutgers University Press, 1952.

Over five thousand five hundred references to articles on streptomycin are catalogued in this 553-page book. There is a 67-page index to authors and a 44-page index to subjects. The type is large and clear. Judging from the obscureness of many of the journals included, the coverage must be nearly complete. This book is indispensable to anyone who needs to review streptomycin literature.

HARRY L. ARNOLD, JR., M.D.

## Nutrition and Diet in Health and Disease.

By James S. McLester, M.D., and William J. Darby, M.D., Ph.D., Sixth Edition, 710 pp., Price $10.00, W. B. Saunders Company, 1952.

The sixth edition of this book is no less amazing than earlier editions. Pertinent and practical information dealing with normal nutrition and dietary treatment of disease is collected in readable form in one book. In this one book there is information that would otherwise have to be searched for in Sherman's *Food Products,* Sherman's *Chemistry of Foods and Nutrition, The Handbook of Nutrition; Clinical Nutrition,* and a diet manual. The index is easy to use and the bibliography is extensive. The chapter on proteins includes a discussion of recent work on amino acids and the necessity to supply sufficient calories to spare protein for its specific functions.

The Feeding of Infants is discussed by P. C. Jeans. Charles C. Lund, M.D., of the Department of Surgery of the Harvard Medical School wrote the chapter on Nutrition in Surgery.

The appendix includes a description of special methods of feeding; the most recent weight tables; dietary standards; a table of the sodium and potassium content of foods and water. The table of food values is entirely new. It is a reprint of the United States Department of Agriculture's Handbook and which is the most recent and reliable of such compilations and includes the new physiological energy values.

MARJORIE G. ABEL, M.S.

## Pharmacology in Clinical Practice.

By Harry Beckman, M.D., 839 pp., 152 figures, Price $12.50, W. B. Saunders Company, 1952.

This book is the clinicians' delight. In the writing of this text the author fully considered the most desirable qualities a busy medical practitioner seeks in a pharmacology book. The text is comprehensive and surprisingly up to date, and the information contained in it is concise, to the point, and practical. I recommend this book as a must to all practicing physicians.

ROBERT C. H. CHUNG, M.D.

## Handbook of Orthopaedic Surgery.

By Alfred Rives Shands, Jr., B.A., M.D., Fourth Edition, 644 pp., Price $8.00, C. V. Mosby Company, 1952.

This book is a valuable addition to the library of both the general practitioner and the orthopedic surgeon as a source of quick reference. The diagnosis and treatment of orthopedic conditions are presented concisely and comprehensively. As a result of his large experience, Dr. Shands has been able to sift the material from orthopedic text-books and the literature, setting down only the pertinent facts. The roentgenograms and illustrations are excellent and there are several new sections on the more recent developments of orthopedic surgery which bring the book up to date.

HARRY B. ALLISON, M.D.

### Surgery of the Eye.

By Meyer Wiener, M.D. and Harold G. Scheie, M.D., D.Sc., F.A.C.S., Third Revised Edition, 449 pp., illustrated, Price $15.00, Grune & Stratton, Inc., 1952.

Every practicing ophthalmologist and student of ophthalmology is familiar with the author's previous editions of this masterpiece of eye surgery. It was not intended to be an exhaustive reference but a handy authoritative concise atlas. Various procedures have been chosen which, in the author's judgment, will serve the best purpose in a given condition. Dr. Harold Scheie has collaborated as coauthor in this third edition and several chapters of the book have been entirely rewritten in order to conform to the many changes and progress in eye surgery. Though the general outline and purpose of the book have not been changed, a number of new operative procedures have been added. The book is exceptionally well illustrated, making it easy for the reader to visualize the various steps in technique. This text is so basically sound, well written and illustrated, that it is a "must" in every ophthalmologist's library.

HAROLD F. MOFFAT, M.D.

### Practical Dermatology.

By George M. Lewis, M.D., F.A.C.P., 328 pp., Price $7.50, W. B. Saunders Company, 1952.

This book, as its title implies, discusses the most frequent skin conditions in a readable but succinct manner. It is lavishly illustrated, with nearly one-third of its pages devoted to excellent plates illustrating large numbers of skin conditions. Each of the ninety-nine plates presents from one to a half-dozen different clear photographs of skin lesions.

There is nothing of significance to criticize in this book. However, I believe its purpose would have been served just as well by omitting some of the "horror" illustrations such as those of mutilating syphilis and leprosy and perhaps the overabundance of pictorial presentations of pemphigus and mycosis fungoides.

The book can be recommended to the general practitioner without reservation.

SAMUEL D. ALLISON, M.D.

### Practical Blood Grouping Methods.

By Robert L. Wall, A.B., M.D., 175 pp., Price $5.00, Charles C. Thomas, 1952.

This monograph is recommended for laboratory technicians and physicians interested in blood grouping methods and their interpretations. It is short, concise and to the point. All the information contained therein is already available elsewhere, but now it is brought together under one cover. The few errors in the text and tables do not detract too much from its value.

LEON E. MERMOD, M.D.

### Air War and Emotional Stress.

By Irving L. Janis, 280 pp., Price $5.00, McGraw-Hill Book Company, Inc., 1952.

Dr. Janis has made a very useful contribution to the literature pertaining to war and civilian defense. This volume will be of more value and interest to those people responsible for civilian defense planning than it will be to the general field of pyschology. The subject matter is particularly concerned with reactions to atomic bombing and uses as source material the most authoritative studies available including the reports of the United States Strategic Bombing Survey. It is dispassionate to the point of being occasionally tedious. However, it is well organized and stimulating as far as his limited subject is concerned. Many of our current psychological understandings are reaffirmed and many specific recommendations for civilian defense planning are made. Every person in the upper echelon of civilian defense operations should be required to study this book.

ROBERT A. KIMMICH, M.D.

## ALSO RECEIVED

### Finality and Form.

By Warren S. McCulloch, M.D., 63 pp., Price $3.75, Charles C. Thomas, 1952.

### Malaria.

By Paul F. Russell, M.D., M.P.H., 210 pp., Price $7.75, Charles C. Thomas, 1952.

### Introduction to Physiological Optics.

By Armin von Tschermak-Seysenegg, 299 pp., Price $10.50, Charles C. Thomas, 1952.

### The Pharmacology of Anesthetic Drugs.

By John Adriani, M.D., Third Edition, 179 pp., Price $9.50, Charles C. Thomas, 1952.

It is clear, graphic and complete and is an extremely valuable reference book.

### Antoine Lavoisier.

By Douglas McKie, D.Sc., Ph.D., 440 pp., Price $6.00, Henry Schuman, Inc., 1952.

This is a fascinating and important book.

### Child Psychotherapy.

By S. R. Slavson, 332 pp., Price $4.50, Columbia University Press, 1952.

### A Vitamin Digest for Blood Formation.

By Thomas H. Jukes, Ph.D., 113 pp., Price $4.00, Charles C. Thomas, 1952.

All about vitamins.

### Surgical Clinics of North America.

Philadelphia Number, December, 1952, pp. 1,563 to 1,903, figs. 487 to 586, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1952.

### Transactions of the Fifth American Congress of Obstetrics and Gynecology.

Edited by George W. Kosmak, M.D., 599 pp., Price $12.50, C. V. Mosby Company, 1952.

### Elementary Medical Statistics.

By Donald Mainland, M.B., Ch.B., D.Sc., F.R.S.E., F.R.S.C., 327 pp., Price $5.00, W. B. Saunders Company, 1952.

Concise, simple and practical.

### A Doctor's Soliloquy.

By Joseph Hayyim Krimsky, M.D., 116 pp., Price $2.75, Philosophical Library, 1952.

Religion in Medicine.

### Textbook of Clinical Neurology.

By Israel S. Wechsler, M.D., Seventh Edition, 801 pp., Illustrated, Price $9.50, W. B. Saunders Company, 1952.

It had to be good to go to seventh edition.

# TERRITORIAL MEDICAL ASSOCIATION REPORTS

## HOUSE OF DELEGATES

Minutes of Meeting
Tuesday, December 16, 1952, at 7:30 p.m.
Mabel Smyth Building, Honolulu

**Present:** Dr. McArthur, presiding; Drs. Richert, S. L. Yee, Brennecke (Kauai), Burden (Maui), Woo (Hawaii), R. Benson, C. M. Burgess, Cushnie, Durant, Dodge, Felix, Fujii, Vasconcellos, West, Liljestrand, Wiig, McCorriston, Wallis (Kauai), Wilkinson and Tompkins (Maui); also Drs. Chung-Hoon, Quisenberry, Richardson, Yamauchi, Giles, Gilbert, White, R. Faus, D. Pang, A. S. Hartwell and Nelson.

**AMA Meeting:** Dr. Hartwell reported on the interim session of the AMA which he had just attended in Denver. (A full report has been printed in the JOURNAL.)

Dr. Faus also attended the AMA meeting in the interests of civil defense and medical care plans. He reported the latest information on the doctor-draft law P. L. 779.

**Industrial Relations:** Dr. Dodge reported that the Industrial Relations Committee, of which he is chairman, has held 7 or 8 meetings since its organization about 4 weeks ago. Discussions have been held with representatives of management and labor. Dr. West added that HMSA is currently meeting with management to consider two possible plans for employee coverage. He also made it clear that if HMSA offers anything to the ILWU, it must be offered to all other members of HMSA. Discussion of the problem followed.

**Radio Program:** Dr. Nelson, chairman of the Health Education Committee, reported briefly on the program "Your Friend, the Doctor" being presented weekly over KGMB. Such a program had been approved by the Delegates at their last meeting in May. The committee now has 10 members who have worked diligently and aired 25 programs on health problems. Larry Stevens has acted as moderator and the expense has been borne by Dairymen's Association. Seventy-two local doctors have appeared on the broadcasts. Dr. McArthur said the Medical Association was proud of the program originated by this committee and hoped it would be continued.

**Christmas Gifts:** Dr. Richert, the treasurer, moved that $25 apiece should be given to Florence Isoda and Mrs. Bennett for Christmas, and $5 to the postman. The motion was seconded by Dr. Felix and passed.

**Veterans' Fee Schedule:** Dr. Richert also asked that the representatives of the County societies bring up at their next meeting the matter of veterans' care and the veterans' fee schedule. The Fee Adjustment Committee needs to know by the end of February of the need for any change in the schedule. It would be desirable to use the HMSA fee schedule and add items not covered. Doctors were urged to check the existing schedule and send in suggestions.

**Chronic Illness:** Dr. Yamauchi, chairman of the Chronic Illness Committee, asked the Delegates to request the Governor to appoint a Chronic Illness Commission initially composed of members of the Chronic Illness Committee of the Hawaii Territorial Medical Association. Dr. White spoke on the rehabilitation phase of the problem, Dr. Pang on home nursing care, Dr. Gilbert on diagnosis, Dr. Giles on prevention, and Dr. Okazaki's report on institutional care was presented.

**Action:** After prolonged discussion, a motion to request the Governor to form a commission for the study of chronic illness, as outlined in the minutes of the Chronic Illness Committee dated November 14, 1952, was tabled. The original motion was made by Dr. Richert and seconded by Dr. West. The motion to table was made by Dr. Burgess and seconded by Dr. Felix.

Dr. Burgess then suggested that certain questions be answered before considering the question again at the next meeting: Where is the money coming from? How will it be appropriated? Who will administer it? How do the states that have such programs like them? What is the attitude of the medical societies in those states toward the program?

**Inclusion of Hawaii:** Dr. Yee, the secretary, read an editorial from the January-February, 1950 HAWAII MEDICAL JOURNAL entitled *Hawaii—U.S.A.'s Statistical Orphan* and presented the following resolution:

### RESOLUTION

WHEREAS, Hawaii's stature in respect to population, economic development, number of physicians, and standards of private and public medical care is equal to that of most states and superior to that of some; and

WHEREAS, National surveys of morbidity, mortality, medical economics and other similar matters are generally confined to the 48 states and the District of Columbia to the exclusion of Hawaii; and

WHEREAS, Comparable statistical data for Hawaii are readily available to the persons or organizations making such surveys; and

WHEREAS, The omission of Hawaii from such surveys deprives us of the opportunity of comparing our standards and accomplishments with those of the mainland United States and is derogatory to us; now therefore be it

*Resolved,* That our Delegate to the American Medical Association be instructed to read the attached editorial into the records of the House of Delegates at its next session; and be it further

*Resolved,* That the House of Delegates of the American Medical Association be formally requested to accord Hawaii in all future surveys and reports the same status as the 48 states and the District of Columbia.

**Action:** On motion of Dr. Burgess, seconded by Dr. Richert, the resolution was unanimously adopted.

There being no further business, the meeting was adjourned at 11:30 p.m.

SAMUEL L. YEE, M.D.
*Secretary*

# COUNTY SOCIETY REPORTS

## HONOLULU COUNTY MEDICAL SOCIETY

A regular meeting of the Honolulu County Medical Society was held in the Mabel Smyth Auditorium, Friday, December 5, 1952 at 7:30 p.m. The program consisted of 10-minute talks on "Pearls" gathered on recent sojourns to the Mainland, by Drs. Strode, Bowles, Arnold Jr., and N. P. Larsen. Dr. Steele Stewart spoke on his "Trip to Korea as Consultant to the Surgeon General."

The meeting was adjourned followed by refreshments which were served on the lanai.

* * *

The Honolulu County Medical Society heard Dr. Selman A. Waksman at their meeting on January 9, 1953. Dr. Waksman, who won the Nobel Prize for his achievement in physiology and medical research, spoke on his discovery of streptomycin and the use of antibiotics in tuberculosis.

Some three hundred people, including members of the Hawaii Academy of Science, of Sigma Xi, and of the University faculty, attended the meeting, which was co-sponsored by the Honolulu County Medical Society and the Oahu Tuberculosis and Health Association.

* * *

The Board of Governors of the Honolulu County Medical Society held a special meeting in the Mabel Smyth Building on January 20, 1953, with Dr. Walsh presiding, and 22 doctors in attendance.

Dr. Dodge, chairman of the Industrial Relations Committee of the Territorial Medical Association, discussed medical care plans proposed by the ILWU and by employers. Dr. Richert, chairman of the Fee Adjustment Committee of the Honolulu County Medical Society, pointed out that the ILWU plans provided fees which were in many instances too small; that they included first visits, which would probably lead to abuses of the plans; that they mentioned no after-care for many surgical conditions; and that there were many inequities of payment. He pointed out that the management plan offered inadequate fees in view of the raising of income limitation, which would make the plan cover nearly 90 per cent of the population; that $25 per year was wholly inadequate for special drugs; that the present HMSA indemnity was wholly inadequate as full coverage for maternity care; that a ceiling of $250 on all cases was inadequate; that the fees for house calls were too low; and that, even with these limitations, $9 per month per employee would not cover the costs.

The plans were then discussed at length and it was unanimously voted to offer to labor and management, in lieu of their proposals, the existing HMSA plans. The Board also voted unanimously against accepting the present Prudential indemnity fee schedule as full coverage for persons earning up to $6,000 combined family income.

* * *

On January 23, 1953, the Honolulu County Medical Society held a special meeting of the general membership in the Mabel Smyth Auditorium with 200 members attending. Dr. Walsh presided.

Dr. Walsh explained the medical care plan proposals, for the consideration of which the meeting was being held. He informed the membership of the action of the Board of Governors. A motion to approve the action of the Board of Governors was made, seconded and discussed at length. Dr. Dodge reported the findings of his Industrial Relations Committee. Dr. Richert reported the findings of the Fee Adjustment Committee in regard to the proposed plans. After some two hours of discussion, the motion to approve the Board of Governors' action was carried with but one dissenting vote. The action of the Board of Governors in declining to accept the Prudential plan as full payment was unanimously affirmed by the membership.

C. M. BURGESS, M.D.
*Secretary*

## KAUAI COUNTY MEDICAL SOCIETY

The regular meeting of the Kauai County Medical Society was held January 13, 1953, at the G. N. Wilcox Memorial Hospital Library at 7:30 p.m. The meeting was called to order by the Vice-President, Dr. Ishii. All members were present. Guests were Drs. R. J. McArthur and Faus, Mr. J. Veltmann and Mrs. Inouye.

Dr. Brennecke gave a brief report on the recent HMSA meeting.

There being no further business, the meeting was turned over to the guest speakers.

Dr. R. J. McArthur gave the annual Presidential Address. His topic covered the scope and current projects of various Territorial committees. Dr. McArthur opined that the most important work was in the field of Industrial Relations. He thought that the Medical Societies should participate more in the industrial sphere. He spoke on the present medical care problem in the plantations and commented on the current Management-Labor negotiations regarding same. It was his opinion that Labor regarded the present set-up satisfactory, but wanted a "voice" in managing the medical care program.

Mr. Veltmann, Dr. Faus and Mrs. Inouye were representing the HMSA. Mr. Veltmann wanted to stress the fact that they were not here *proposing* any plan for any labor group but merely wanted to have the Medical Society's reaction on the proposed Stevedore Medical Plan which the Stevedoring Companies Negotiating Committee had presented to them. He stated that the HMSA had actuarily computed the Hospital, Surgical and Medical benefits and amounts have been included in the monthly premium to cover the additional benefits not offered in HMSA's Standard Plan or Comprehensive Plan. He explained the co-insurance feature under the Medical Service. He pointed out that the Management had included certain considerations as shown on page one as items 1-a, b, c. He requested the Society's decision on the Proposed Medical Plan as presented.

After a lengthy discussion, Dr. Wade was of the opinion that 1-c on the first page relating to the maternity benefits should be left on an indemnity basis, exactly the same as the present HMSA policy. He pointed out that many practitioners who have a large OB practice or do only OB practice deserve considera-

tion. As proposed, it limits the fee which often does not adequately cover the expenses incurred. He thought it was not fair to these men to accept the proposed plan.

It was also brought out that the present house-office calls were on an indemnity fee schedule.

Action: Dr. Goodhue moved, seconded by Dr. Kuhns, that this Society approve the Proposed Stevedore Medical Plan with the exception of the maternity benefit clause, item 1-c page one. It was recommended that it be left on an indemnity basis (exactly the same as the current HMSA policy). All members present voted in the affirmative with the exception of one non-practicing member who did not cast a vote either way.

Dr. Wallis spoke briefly on the Pineapple meeting relating to a Medical Plan and also informed the group that there will be a meeting by the Sugar industry on a similar subject. He asked all plantation physicians to be aware of these meetings and to keep in touch with the current negotiations. It was his opinion that the Medical Societies should endeavor to offer a better plan and then to support it unswervingly.

The meeting adjourned at 10:30 p.m.

* * *

A special meeting of the Kauai County Medical Society was held at Dr. Brennecke's home on January 27, 1953 at 8:00 p.m.

Members present were: Drs. Wade, Masunaga, Goodhue, Cockett, Kemp, Yamauchi, and Brennecke.

Dr. Yerushalmy of the Division of Biostatistics, School of Public Health, University of California, was also present. Dr. Yerushalmy, a participant of the Special Convention of the Rural Health Organization of the United Nations, discussed the proposed fetal death survey that will soon be made on Kauai. He urged complete cooperation from the members of this Society in this study. The President appointed Drs. Goodhue and Masunaga to meet with Drs. Kemp and Yerushalmy for the purpose of formulating the basic pre-natal and post-natal questionnaire and record which all practicing doctors on Kauai will use in the survey.

A motion was made by Dr. Wade that the Secretary of the Society contact the President of the Territorial Medical Association and also the A.M.A. to ascertain the status of the "fetal death" survey before the members actively participate in this study. This was seconded and passed unanimously.

The prime purpose of this special meeting was then presented—that is, writing a reply to the Medical Plan proposal which some of the Society members received from Jack Hall. The Hall proposal was read in toto by the President. After some discussion Dr. Wade moved that the Hall proposal be rejected by the members. This was seconded and passed unanimously. Dr. Brennecke then suggested that the letter could read as follows: "The Plan you submitted to a few of our members was brought before the Society for discussion. The Society unanimously disapproved of the Plan." This letter met with the approval of all members present.

Dr. Brennecke presented several motions which were passed unanimously:

1. That the Kauai County Medical Society request the President of the Territorial Medical Association to appoint the members from all component medical societies serving on the HMSA Medical Committee to the present Territorial Industrial Relations Committee in order to effect a closer liaison between the Territorial Industrial Relations Committee and the Medical Committee of the HMSA.
2. That the Kauai County Medical Society request the President of the Territorial Medical Association to ask the Territorial Industrial Relations Committee to prepare a comprehensive medical plan that can be offered to the entire population.
3. That the Kauai County Medical Society recommend to the President of the Territorial Medical Association that the name of the present Territorial Industrial Relations Committee be changed to the Territorial Medical Economics Committee.

The meeting adjourned at 10:30 p.m.

* * *

The regular meeting of the Kauai County Medical Society was held February 10, 1953, at the G. N. Wilcox Memorial Hospital Library at 7:30 P.M. The meeting was called to order by the President, Dr. Brennecke.

Members present were Drs. Ishii, Masunaga, Kuhns, Fujii, Goodhue, Wallis, Cockett, Kim, and Brennecke. Guests were Drs. Thouin, Tom and Brown.

Dr. Brennecke presented several communications:

(1) From Mr. Veltmann, HMSA, requesting the names of a director and alternate director to the board of HMSA as soon as possible.
(2) From Mr. Veltmann regarding the reactions of the various County Societies on the proposed Stevedore Medical Plan.
(3) From Mrs. Bennett regarding the recent visit of Dr. Middleton, cardiologist, stating that he was not able to come to Kauai because of the limited time.
(4) From Dr. R. J. McArthur, President of the Territorial Medical Association, informing the Society of his views on the three motions that were passed at the recent special meeting relating to the HMSA Medical Committee and the Industrial Relations Committee.
(5) From Dr. Samuel Allison regarding the Public Service Committee and the proposed program in the field of radio and television.

The application for membership by Dr. Richard Yamauchi was accepted unanimously.

The Nominating Committee composed of the members of the Board of Censors presented the following names as candidates for office for the coming year:

President—Dr. Clyde Ishii
Vice-President—Dr. Peter Kim
Secretary-Treasurer—Dr. Richard Yamauchi
Board of Censors—Dr. Marvin Brennecke to serve for three years.
Board of Directors HMSA—Dr. Burt Wade. Alternate Director—Dr. Marvin Brennecke.

Delegate and Alternate Delegate—Deferred until the next meeting.

There being no further business, the meeting was turned over to the guest speakers, Dr. Laurence Thouin who spoke on "Principles of Treatment in Gynecological Endocrinology" and Dr. K. S. Tom who spoke on "Highlights in the Bleeding in Third Trimester of Pregnancy."

PETER KIM, M.D.
*Secretary*

## HAWAII COUNTY MEDICAL SOCIETY

The 327th regular meeting of the Hawaii County Medical Society was held on Jan. 22, 1953 at 8:00 p.m. at the Hilo Country Club with President S. Kasamoto presiding. There were 21 members and 10 guests present.

Dr. James E. Mitchell was accepted as a new member.

By motion of Dr. D. Woo, seconded by Dr. Willett, the following men were chosen for surgical consultants to medical indigent program: Drs. Mizuire, Kutsunai, Brown and James E. Mitchell.

The first speaker of the evening was Dr. Samuel Allison of Honolulu who spoke on the clinical aspects of skin disease.

The next speakers were Dr. Faus, and Mr. Veltmann representing the Hawaii Medical Service Association. The former gave a short resumé of what happened at

the Kansas City Meeting of Civilian Defense, touching on the subject of Doctor-draft call Law P. L. 779.

Mr. Veltmann was introduced next. The ILWU has at hand a sum of $40,000 in escrow and is now proposing a plan of both contract and panel type of medical practice for the doctors of the Territory. The HMSA has also met with the representative of the management, namely, the stevedoring companies negotiating committee, and has come up with the proposed Stevedore Medical Plan. A memorandum was distributed among the members present. After a lengthy discussion, a resolution was put to motion.

Dr. A. Orenstein moved that the Hawaii County Medical Society approve the plan as outlined by the management of the stevedoring companies' negotiating committee. Seconded by Dr. H. Yuen, whereupon it was unanimously carried.

A companion action was also taken on the ILWU's proposed Longshore Medical Plan. After a lengthy discussion, a motion was made by Dr. W. Bergin that we do not accept their proposed Medical Plan. This was seconded by Dr. H. Yuen again and unanimously carried.

The secretary was then instructed to inform the ILWU of our action.

As a final motion of the evening, Dr. S. Mizuire moved that the representative of this society be instructed to inform the Territorial Industrial Relations Committee that the Hawaii County Medical Society request that they formulate a comprehensive plan, applicable to the entire population within the scope of their paying ability. Seconded by Dr. H. E. Crawford and unanimously approved.

There being no further business, the meeting adjourned at 11:56 p.m.

RICHARD A. YAMANOHA, M.D.
*Secretary*

## MAUI COUNTY MEDICAL SOCIETY

The regular monthly meeting was held at Central Maui Memorial Hospital, with 18 regular members present.

Dr. Robert A. Rose was introduced as a guest. He has recently arrived from the mainland to be associated with Dr. Shimokawa at Pioneer Hospital. Other guests present were Dr. Mei, Mr. Sheffield and Mr. Veltmann.

Mr. Veltmann from H. M. S. A. then spent considerable time explaining a new H. M. S. A. plan which had been offered to the I. L. W. U. for stevedores. He further stressed that the doctors should take more interest in the H. M. S. A. as it is their insurance plan. Also, he reminded the Society that the appointment of a member and alternate to serve on the H. M. S. A. Board of Directors must be done by March 1.

Dr. Underwood moved that the Society go on record as approving and supporting the H. M. S. A. plan for stevedores as presented by Mr. Veltmann and also that the Society approve the three points mentioned by him, namely as to income clause, co-insurance and obstetrical fees. This was seconded by Dr. Shimokawa and motion passed, 15 yes, 2 no, 1 absent.

Dr. McArthur then spoke to the Society as the Territorial President. He spoke of the coming annual meeting on Maui. He spoke at some length of the importance of the Industrial Relations Committee and that particularly during this time of bargaining between labor and management they should be fully aware of all developments. Their advice and help should be given if needed and they should keep the Societies informed of developments in any medical insurance plans proposed.

Dr. Wilkinson reported on Pineapple Management and physicians' meeting held Jan. 10 in Honolulu. Mr. Sheffield then spoke on the Union objective, on panel type medicine vs. free choice of physician and on management's willingness to consider better medical plans for employees.

Dr. St. Sure submitted his resignation as Chairman of the Pathologist Committee as he felt he had done all he could in procuring applicants for a pathologist for Maui County. It is now the problem of Central Maui Memorial Hospital to decide on further action.

* * *

A special meeting was called by President Burden at the Central Maui Memorial Hospital to consider and review a medical plan which had been mailed to all the physicians of Maui County by the I. L. W. U.

Present at the meeting were the following members: Doctors Cole, Tompkins, H. Kushi, Ferkany, Haywood, Underwood, Patterson, St. Sure, Sanders, Wilkinson, Reppun, K. Izumi, A. Y. Wong, Tofukuji, Ohata, Rockett, Shimokawa, Kashiwa and Kanda. Dr. Rose attended as a guest, also five members of the local I. L. W. U., with Mr. Yamasaki acting as spokesman.

Mr. Yamasaki reviewed the medical insurance plan and explained it in detail. He then answered questions from the members, regarding this new proposed plan. The I. L. W. U. representatives were then excused and the meeting opened for general discussion.

Dr. Reppun moved and it was seconded by Dr. Sanders, that individual replies not be made and that any reply made be sent by the Society as a group. This motion was amended to the effect that any decision reached by the Society be communicated to Jack Hall of the I. L. W. U. by letter and that copies be sent to management, the other County Societies, H. M. S. A. and to the President of the Territorial Society. This motion was passed.

Dr. Burden then pointed out that there were four choices: 1) Complete acceptance; 2) Complete objection; 3) Modification; 4) Submission of a new plan to be drawn up by the Territorial Society Industrial Committee. After considerable discussion it was moved by Dr. Sanders that we reject the plan as submitted. This was seconded by Dr. Shimokawa. After more discussion, this motion was voted on and passed. All members present voted in the affirmative except Dr. Izumi and Dr. Tofukuji, who voted against this motion. A letter was then composed as follows:

International Longshoremen's & Warehousemen's Union
451 Atkinson Drive
Honolulu 14
Att: Mr. Jack Hall
Dear Mr. Hall:

The Longshore Medical Plan, as proposed by the I.L.W.U., was discussed at a special meeting of the Maui County Medical Society on Friday evening, January 23, 1953. The plan as submitted was voted as unacceptable.

At a regular meeting of the Maui County Medical Society on Monday, January 19, 1953, this Society voted to approve a medical plan for Longshoremen as submitted by the H.M.S.A.

Sincerely,
EDMUND TOMPKINS, M.D.
Secretary

It was moved by Dr. Patterson, seconded by Dr. Sanders, that this letter be sent as written and submitted to the Secretary. Carried unanimously.

EDMUND TOMPKINS, M.D.
*Secretary-Treasurer*

# HMSA—Its Place in the Community

## Professional and Public Relations

J. R. VELTMANN, *General Manager*

Public and industrial relations are an important and essential part of the business world today. In the HMSA program, good professional and public relations are vital. As a non-profit association, HMSA does not use such media as radio and newspapers for advertising, but depends entirely on its own publications and highly trained employees to promulgate HMSA and its values to our participating doctors, hospitals, over 63,000 members and the people of Hawaii.

HMSA's professional relations program is under the direction of the Medical Director and consists of a staff which includes a registered nurse, a service consultant, service representatives and two clerical assistants.

The nurse has access to all medical history files of the members and administrative procedures relative to claim adjustments. She is available to discuss medical problems with participating physicians, and spends a good deal of time in consultation with the Medical Director over such problems. She is the authorized employee at HMSA to review claims with members who desire clarification of services paid under their membership certificates. Claim review with members is permitted only if such claim involves the member personally or members of his immediate family. These records are otherwise confidential and are not reviewed with any other individual. In addition to servicing doctors and members, the nurse plays an active part in our relations with hospitals. On admission of an HMSA member, the hospital contacts the Association for verification of membership and authorization of services. The case is reviewed and services authorized in accordance with the member's certificate of benefits. (Authorizations are later confirmed in writing.)

The Service Consultant of HMSA is in the field each day on personal contacts with doctors, nurses, doctor office personnel, hospital admission clerks and hospital office personnel. Her responsibilities are primarily to assist doctors and hospitals with their administrative problems and to offer on-the-spot assistance on any HMSA problem. Each new doctor who establishes practice in Honolulu is called on personally by the Service Consultant who explains HMSA plans, the fee schedule and a suggested accounting procedure for handling HMSA accounts. Certain promotional materials are left with the doctor for his patients to review, as well as a supply of billing forms. Since the inception of the Service Consultant position six months ago, personal contact has been made with practically every doctor in the community and the number of requests for assistance has made this service a necessary part of our program.

Planned seminars for groups of doctors' office personnel and hospital personnel are held at regular intervals to review over-all HMSA operations and problems. A series of such seminars was recently held on all islands and covered history and basic principles of the Association and its objectives for the future. These seminars have been very helpful to the Plan, as ideas offered for improvement of our services are developed and incorporated in the operations of the Plan. Reports from personnel attending these seminars indicate that they should be continued and scheduled whenever changes occur.

Service representatives are available at the office and in the field to explain HMSA services and enrollment procedures and to clarify problems.

Participating doctors are kept informed of the operations of the Association through a regular quarterly publication entitled "Report to Doctors" wherein all changes and suggestions are published for quick reading. Members are kept informed through publication of an Annual Report to Members wherein the operations of the year are reviewed graphically and pictorially as well as figuratively.

A publication, "Facts about HMSA," has been printed and distributed with a dispenser to all doctors and hospitals as general information for the public. This publication briefly outlines the many features of our Association and offers information relative to enrollment.

We hope through these means to prove that medical care should remain a free enterprise and that the most economical way to protect oneself against medical bills is through a pre-payment plan. We are also convinced that our efforts should be concentrated on professional relations, as our participating doctors and participating hospitals are truly our best public relations media.

# NOTES AND NEWS

## PERSONALS

**Dr. Robert S. Spencer** has assumed the position of supervising psychiatrist at the Territorial Hospital in Kaneohe. Dr. Spencer was graduated from Texas Christian University in 1940. He received his medical training at Temple University School of Medicine and graduated in 1943. He interned at Harris Hospital in Fort Worth from 1944 to 1945. Following two and one-half years of military service, he received his psychiatric training at the University of Colorado under Dr. Franklin Ebaugh, and also at the Colorado General Hospital. Dr. Spencer is married and has two small children.

Also joining the staff at the Territorial Hospital are **Drs. Dean Robbins Archer** and **Bertrand Tenenbaum.** Dr. Archer received his medical training at Nebraska Medical school and interned at St. Elizabeth's hospital at Washington, D. C. Upon completion of his internship in 1947, he started psychiatric training with the Veteran's Administration. For the past two years he has been in charge of the insulin and electric shock treatments at the Arizona State Hospital. **Dr. Tenenbaum** received his medical training at the University of Lausanne, Switzerland, graduating in 1950, he completed his internship at Queen of Angels Hospital in Los Angeles. Dr. Tenenbaum has been in private medical practice in Los Angeles up to the present time.

**Dr. Francis Kin Lum,** formerly of Honolulu, returned to the Islands after an absence of eighteen years. Dr. Lum received his preliminary training at St. Louis College. He received his M.D. degree from St. John's University in Shanghai. Until 1945 Dr. Lum and his Dr. wife worked at the Chadwick Memorial Hospital near Chengtu. After that both he and Mrs. Lum worked at the Columbia Division of the Bellevue Hospital and also at the Columbia Presbyterian Medical Center in New York. Later Dr. Lum became a fellow at the Memorial Center for cancer and allied diseases. Dr. Lum is a diplomate of the American Board of Surgery. He has opened his offices for the practice of general surgery at 289 South Vineyard Street.

**Dr. Herbert Y. H. Chinn** announces the opening of his office at Room 30 Young Hotel, with practice limited to urology. Dr. Chinn is a graduate of St. Louis College and a former student at the University of Hawaii. He received his M.D. degree from Boston University School of Medicine in 1944. He served one year's internship at the Kings County Hospital in Brooklyn, N. Y., followed by a year of residency in genito-urinary surgery at the same institution. From 1947 to 1949 he served at Tripler Army Hospital. Before that he was on the staff at the Emergency Hospital in Honolulu. For the past year and a half he was chief resident at the college division, State University Medical Center at the New York School of Medicine.

**Dr. Ralph Cloward** presented a series of three color slide lectures on his recent round the world trip. He donated his pictures and his time for the benefit of the Latter Day Saints Church, all proceeds to go into a building fund for a new chapel.

**Dr. and Mrs. T. A. Casey** and four children left for Vancouver, Washington, where Dr. Casey will be chief of orthopedic surgery at the local Veteran's Hospital. A farewell aloha party in their honor was jointly given by **Dr. and Mrs. John Felix, Dr. and Mrs. John Bell** and **Dr. and Mrs. Robert Bailey.**

Licenses to practice medicine in the Territory were issued to **Drs. Thomas J. Albert, Maxwell D. Boyd, Robert A. Kimmich, Richard D. Knotts, Richard D. Moore, Jerome Peacock, Grant Stemmermann, Francis Kin Lum** and **George Warren Henry.**

**Dr. Clarence Fronk** recently returned from a successful tiger hunt in India. This was Dr. Fronk's second trip to India within the past three months. During his recent expedition he was the honored guest of the Maharajah of Indore, and was fortunate in having shot the heaviest tiger (10 feet in length and weighing over 500 pounds). While in Indore, Dr. Fronk addressed the Indore Medical School. **Dr. Howard Liljestrand** had accompanied Dr. Fronk on his excursion to take movies of the hunt. He is expected to return to Hawaii soon.

**Dr. K. M. Amlin** announces the opening of his offices at 309 South Vineyard Street for the general practice of medicine and surgery.

**Dr. Vernon Boido** has assumed the duties of chief resident at St. Francis Hospital in July of 1952. From June 1950 to 1952, Dr. Boido was resident at Kula Sanitarium on Maui.

**Dr. Marion Hanlon,** formerly of Kohala Plantation on Hawaii, has assumed the position of chief resident at Children's Hospital on January 19. Dr. Hanlon was called to active duty by the Army in June of 1951.

**Dr. and Mrs. Frank Gaudin** announce the arrival of their fifth child, a daughter, Anne, born on December 22. Dr. Gaudin has been practicing in New Westminster, British Columbia since he left the Islands.

**Dr. Alvin Majoska** has been certified by the Board of Legal Medicine. This Board is composed of qualified medical examiners and other physicians whose primary work is in medical jurisprudence or forensic medicine. Dr. Majoska is the only M.D. certified in this branch of medicine in the Territory.

**Dr. Frank Spencer** left for the Annual West Coast Conference of Obstetrics and Gynecology in Los Angeles.

**Dr. C. V. Caver** announces the opening of his office for the practice of Dermatology at 1124 Alakea Street. He was medical director of Kalaupapa from 1950 to 1952.

**Dr. George Hill Hodel** has been appointed psychiatric consultant to the Psychological Clinic at the University of Hawaii where he is also engaged in research.

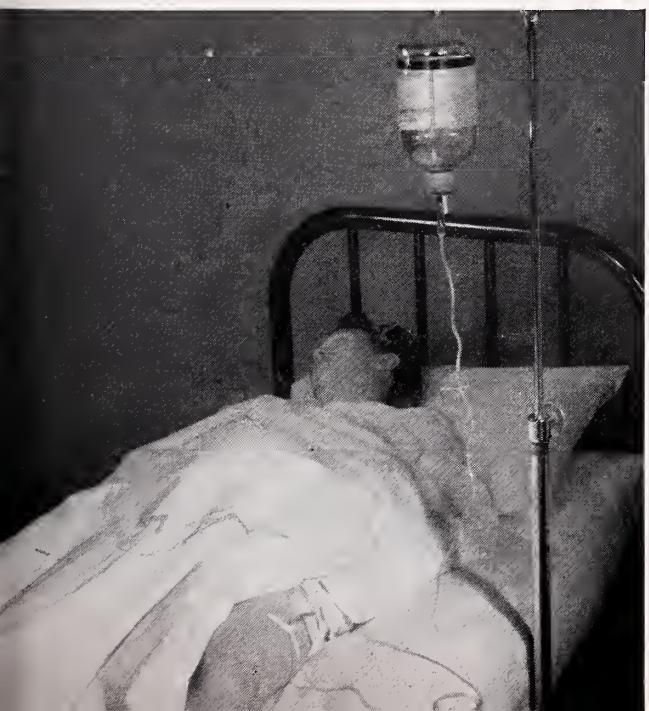
**Dr. A. Leslie Vasconcellos,** President of the Hawaii Chapter of the American Academy of General Practice, is leaving on February 27 for a Mainland trip. On March 14 he will represent the Territorial Medical Association at a special session of the AMA House of Delegates in Washington, D.C. Between March 22 and March 26 he will attend the annual meeting of the American Academy of General Practice at St. Louis. Also attending this meeting as delegate from Hawaii will be Dr. Edmund L. Lee.

# Use of Alidase® Permits Subcutaneous Administration of Fluids at Usual Intravenous Rates



**In operative states**—Alidase circumvents the complicating factors of venous thrombosis and "wornout" veins which frequently make fluid administration by vein difficult and dangerous. Simplicity and safety of Alidase make hypodermoclysis a method of choice for preoperative preparation and postoperative maintenance.

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Addition of Alidase to the first few cubic centimeters of fluid during hypodermoclysis speeds absorption to a degree approximating that of the intravenous route. Use of highly purified hyaluronidase in this manner avoids the well-known difficulties encountered with venoclysis, saves valuable nursing time and is more comfortable to the patient.

Hechter, Dopkeen and Yudell[1] have found that the use of hyaluronidase has "markedly increased the rates of absorption and administration of hypodermoclysis with no untoward reactions." They also found that extremely small amounts of this enzyme facilitated the absorption of fluids in that greater amounts of fluids were absorbed by the patient in a given period of time and that the localized swelling following hypodermoclysis disappeared more promptly.

Similar results with Alidase were recounted by Schwartzman, Henderson and King.[2] They observed "that absorption of various types of solutions, such as saline, glucose in saline, Hartmann's solution, Ringer's solution, penicillin, streptomycin, Adrenalin, and procaine was facilitated in every case."



**In toxemias of pregnancy**—Urgently-needed parenteral fluids may be administered subcutaneously with the aid of Alidase, eliminating risk of thrombosis attending repeated intravenous administration of electrolyte solutions. Alidase is the highly purified Searle brand of hyaluronidase and is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

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1. Hechter, O.; Dopkeen, S. K., and Yudell, M. H.: The Clinical Use of Hyaluronidase in Hypodermoclysis, J. Pediat. 30:645 (June) 1947.
2. Schwartzman, J.; Henderson, A. T., and King, W. E.: Hyaluronidase in Fluid Administration: A Preliminary Report, J. Pediat. 33:267 (Sept.) 1948.


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**Drs. Gordon Chang, Richard K. C. Chang** and **Warren L. Wong** have recently been called to active service by the Army. **Lt. Sydney T. Fujita** is now located at Tripler Army Hospital. An interesting letter has been received from **Lt. Chew Mung Lum** in France. His address is 57th Field Hospital, APO 216-2, care of Postmaster, New York. **Lt. Kenneth Rusch** has returned to Tripler from Eniwetok. **Lt. Edmund Lum, Capt. Samuel Tashima** and **Lt. Samuel Lui** are all on duty in Korea. **Capt. Kwai Sung Chang** is now on rotation in Japan.

## NEWS

### International College of Surgeons

Qualifying examinations for Fellowship in the United States Section of the International College of Surgeons will be held on the following dates in 1953: May 4 and 5, August 10 and 11, and November 2 and 3. The examinations will be given at the Cook County Graduate School of Medicine, and the Cook County Hospital. Applicants are requested to address communications as follows:

Harry A. Oberhelman, M.D., Secretary
Qualification and Examination Council
1516 Lake Shore Drive
Chicago 10, Illinois

### The American Congress of Physical Medicine and Rehabilitation

The 31st annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held on August 31, September 1, 2, 3 and 4, 1953 inclusive, at the Palmer House, Chicago, Ill.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

### TB Symposium for GP's in Saranac Lake Next Summer

The Second Annual Tuberculosis Symposium for General Practitioners will be held in Saranac Lake, New York from July 13 through 17, 1953. It is approved by the American Academy of General Practice for 26 hours of formal credit for its members.

The Symposium is sponsored by the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The registration fee is $40 for A.A.G.P. members and $50 for non-members. Registration is limited to 100 doctors.

Many physicians who attended last year's symposium brought their families to Saranac Lake. So that families might have use of the car to enjoy the many recreational facilities of the Adirondack Mountains, free bus transportation was provided for physicians from Saranac Lake to the various meeting places. This practice will be followed again this year.

Complete information concerning this program can be obtained by writing: Richard P. Bellaire, M.D., Tuberculosis Symposium for General Practitioners, P. O. Box 707, Saranac Lake, New York.

### National Board

The Honolulu Subsidiary Board of the National Board of Medical Examiners has set June 16, 1953, as the date for the examination to be held this year.

Any candidates interested in completing Part III of the examination should communicate with Dr. A. S. Price, the local secretary prior to May 1, 1953, and signify their desire to register.

The fee for Part III is $40.00.

# UMI MAKAHIKI I HALA*

### Women's Ambulance Service Patrol (WASPS)

A group of sixty business women in Honolulu have been trained by the Provisional Ambulance Battalion of the Army for the driving of ambulances and the care and loading of casualties.

* * *

The O.C.D. Emergency Hospital at Huleia on Kauai has been completed, equipped and staffed.

The hospital at Waimea, Kauai, is complete and will be occupied within a week or so. It is built up the canyon at a distance above the confluence of Waimea and Makaweli rivers and thus rendered safe from attack from the sea.

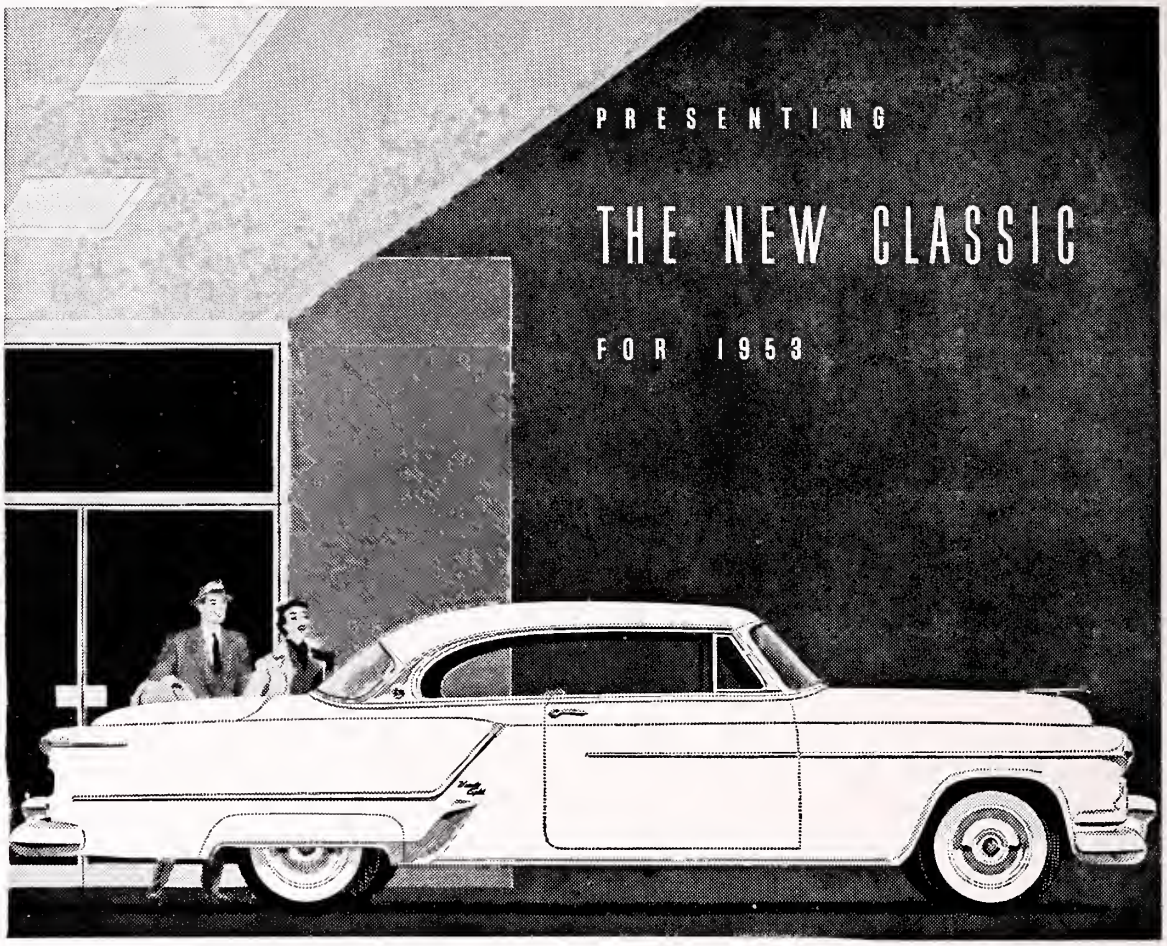
The O.C.D. Emergency Hospital at Olaa on Hawaii has been completed and is occupied.

The new wing of the Hilo Memorial Hospital has been equipped so that it has a potential capacity of 100 casualties.

### Dr. Baehr's Visit

The outstanding event since the last report was the visit of Dr. George Baehr, Chief Medical Officer of the National Office of Civilian Defense . . . he publicly expressed his approval of the general medical set-up and felt that it should continue along the same lines with minor changes in control and organization only. He particularly emphasized the fact that in England where greater experience has been had than in any other place, they have found it eminently desirable to have medical personnel and equipment at their posts of duty and not outdoors during air raids, until an incident has been reported to the control center which necessitates the dispatching of a specific unit to care for casualties.

*Ten years ago. From Volume 2, Number 4, March-April, 1943.




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# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAM, *Executive Secretary,* Honolulu

BULLETIN COMMITTEE

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## ACTIONS OF YOUR BOARD OF DIRECTORS

December 10, 1952—1:15 p.m. to 5:10 p.m.

Eleven members present, one absent.

*Discussed* inequities in current status of job reclassification by Salary Standardization Board between public health nurses and social workers. Miss Laura Draper was invited to participate in this discussion.

*Moved* that a letter be sent to the Salary Standardization Board asking that there be a horizontal review of, and that equity be established in, the classification of social workers and nurses.

*Moved* that secretary set up a formula computing the total actual membership per district needed to meet the NATH budget for 1953. This formula worked out for each District Association indicating membership and monetary equivalent to be sent each district treasurer and president, and to NATH Board members.

*Report* was made by the Executive Secretary and Miss Harriet Kuwamoto on their visit to Hilo Memorial Hospital as representatives of the Nurses' Association.

*Moved* that Miss Kuwamoto's transportation be paid by NATH.

*Discussed* 1953 Annual Convention dates. To be referred to membership.

*Appointed* NATH committees for 1953.

*Moved* that only a few committee chairmen be requested to report at each Board meeting, planning that each committee will give one or two reports during the year. Also that Territorial Section chairmen be asked to report progress.

*Planned* tentatively for future Board meetings considering budget and meeting and annual convention on Maui.

*Heard* report by Mrs. Lois Bell on Economic Security workshop held in Omaha, Nebraska. (This report appeared in the February issue of the INTER-ISLAND NURSES' BULLETIN.)

*Announcements*:

Executive Secretary to take vacation in December.

Mrs. Elizabeth McCall to represent NATH at ANA.

Advisory Council in New York in January.

Revised by-laws will be printed in February INTER-ISLAND NURSES' BULLETIN.

Reprints will be available for members who desire them.

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*"Tuberculosis is notorious for the difficulty of detecting it in its early stages. By the time it is discovered, the disease usually has been transmitted to others. In view of this fact, no method of treatment will solve the TB problem in short order, although improved methods should help hasten the far-off day of eradication of tuberculosis. A good vaccine, superior to BCG—the one most widely used at present—would have greater potentialities for rapid control of tuberculosis than any method of treatment. There is no simple solution to the tuberculosis problem. The disease, because of its infectiousness, its present prevalence, its symptomless onset, its long duration, its tendency to recur even though once arrested, is one of the most complex and costly public health problems in the United States."* James E. Perkins, M.D., Annual Report of National Tuberculosis Association, April 1, 1951 to March 31, 1952.

## SOME SUBJECTIVE REFLECTIONS ON THE PERSONALITY OF THE HAWAIIANS

CLAIRE CANFIELD

Although there is a paucity of description in the early literature as to the characteristics and nature of the Hawaiians, these remarks from Stewart's "A Residence in the Sandwich Isles" are noteworthy: "greatly commended themselves to us by their artlessness and simplicity, and an apparent sprightliness and intelligence of mind," "great beauty of person . . . ease of action . . . unaffected dignity of deportment," "countenance open and intelligent."

One is impressed by the nature of an Hawaiian. There is about him an indefinable quality which defies description. It is as if he possessed, for want of better terms, "great inner resources," an inner freedom of spirit. It is apparent in his mien, his manner of relating to others, and his infinite capacity for joy and beauty.

The derivation of these attributes may well lie in the "individual's concept of himself as a person," a person whom he himself can respect and whom he has come to realize that others respect or hold in some affection. This concept of himself is not happenstance—it is "set" from experiences of infancy and childhood in the supporting framework of family relationships—cultivated in infancy, nourished and maintained in the later phases of growth and development.

Family structure in old Hawaii was extremely important, a closely knit unit, which gave to the newcomer in the group a growing sense of "belongingness" and "security" so essential to optimum growth and development in the area of personality. Because of its extended nature (that is, aunts and uncles bearing practically the same relationship and obligation to him as his parents) the child's sense of security was reinforced. Children, moreover, were cherished, for their presence insured the perpetuation of a people, their traditions, history, etc. which many times during the years and rigors of wandering and resettlement had hung in jeopardy. The acceptance and affection accorded them were without doubt factors in incorporating a sense of personal worth, self-esteem, and self respect in the "individual's concept of himself."

It seems almost indisputable that attitudes toward children generally were warm and friendly, although the institution of infanticide undoubtedly flourished at one time. Its practice on one hand is said to have been rationalized on the basis of sickness, or deformity, or distress, while more recent, well informed authors state there is no evidence that either it or fetal abortion ever existed as a social institution in Hawaii.

Child rearing patterns were such as to lend themselves to a healthy integration of infantile experiences, i.e., the child remained with his mother until weaned at one year, was fed at her breast by a wet nurse, and was handled in a permissive way which obviated harsh, undesirable controls. Permissiveness to a degree and absence of inappropriate controls are said to build positive attitudes in children which, later, even punitive treatment cannot seriously undermine. These more or less traditional patterns employed by Hawaiians are viewed today by modern psychiatry as having undeniable merit.

The family unit beyond the function of protection and security served as an agency of acculturation—to pass on to the child knowledges and skills, traditions, etc. and to some extent spiritual values. This gave added strength to family ties and family relationships, also tended to inculcate in children a feeling of deference for older and wiser persons whose role was to impart such information. Since there was no written language, the store of non-material culture—meles, chants, legends, genealogies, etc. was handed down from generation to generation by word of mouth. This mode of education has certain relative value in that it requires active participation on the part of both teacher and learner. Also the elder's emotional investment in the material tended to make it more meaningful to the learner, giving him a feeling of abiding interest and pride in what had gone on in the history of his kind. This assumption is certainly validated in the indestructible race-consciousness of the Hawaiians, the perpetuation of which is surely tied in with attitudes and inter-personal relationships associated with the process.

The telling of legends, etc. apparently was begun early, which is good, for children exposed early to conversation in a consistent manner usually develop not only earlier and better speech but the tempo of their mental as well as social development is accelerated. Mental acumen and acquisitiveness on an adult level to a great degree is dependent on the responsiveness of adults in the child's early environment, and the level of intelligence of the Hawaiians is frequently attested in the writings of the early voyagers and missionaries.

The traditional manner of play with children was wise psychologically—making model houses,

toy canoes, building heiaus and conducting appropriate ceremonies in relation to them. This served as preparatory experience to adulthood, precursor roles of those later to be assigned to them. Mastery of physical activity in sports and games, encouraged by elders, provided a means for expression and achievement, factors of importance in nourishing the child's growing sense of personal worth. Also they were a means to drain off and redirect normally aggressive impulses of childhood into socially acceptable channels, and a means whereby to learn the gratifications inherent in participation and cooperation.

Certainly it would appear that the emotional needs of children were met with considerable adequacy in the culture of old Hawaii—met intuitively with warmth and understanding. Here then is evidence, in part at least, of how and why the Hawaiians lived happily and productively. The early "set" had been propitious, a condition which reflected in personality and concurrently in behavior. Giving license to a good deal of reconstruction it seems that the family and its members were potent forces in the evolution of this so-called characteristic Hawaiian personality; their permissiveness, encouragement and recognition helped children unfold their potentialities socially, emotionally, and intellectually in a natural, simple way so as to be free of crippling handicaps in the three aforementioned areas. Incidentally, the old Hawaiians had some notions about personality too. They thought the child's personality was inherited from his parents, chiefly those characteristics portrayed by parents during the infant's embryological development. If, in this period, the parents were lazy, happy, or what have you, the child would be also. This concept of course is limited, but children are indeed much like their parents. However, this is not so much a matter of inheritance, per se, as it is a matter of imitation and identification and the incorporation of parental attitudes; and rather than parental influence in terms of personality being confined exclusively to life in utero, it runs the whole gamut of the child's relationships with his parents. Notwithstanding, the old Hawaiian concept had the germinal seed of insight into the problem.

Many factors in the culture tended to nourish and maintain this "set" as individuals progressed into adulthood.

Strong family bonds gave an enduring sense of protection and security, for an individual member could rely on his family to seek revenge, mete out punishment or demand recompense when he had been put upon. The common phenomena of large families and close family ties enriched living in terms of wide and varied interpersonal relationships and in terms of mutual helpfulness.

While numerous motivations were manifest in the immensely popular games and sports (collection of taxes at Makahiki Festival and gambling) an important aspect of these, not to be overlooked, was the opportunity they provided for socializing and reaffirming the solidarity of the larger group. Swimming, surfing, canoe racing similarly had subtler meaning than mere exercise of physical activity. The pride which skill and prowess in motor activity engenders is a contributory factor in the individual's concept of himself—it tends to "set" and reinforce his feeling of being up to situations, his sense of adequacy and achievement. Then too, great joy and exhilaration is manifest and inherent in physical activity when one is able to acquit himself well.

Artistic self-expression and a highly developed mastery of skills are apparent in the material culture of the Hawaiians. Wood carving, bowls, decorated gourds, colorful, exquisitely designed and water-marked tapa, intricate feather work, personal adornments, etc., reveal in essence a freedom of expression characteristic of happy people. Too, regard for beauty and the urge to express it in simple ways and in simple things reflects an inner security and contentment. That psychological burdens inhibit creativity, productivity and spontaneity is a generally accepted principle in mental health. When one considers the limited natural resources available for the manufacture of clothing, household goods, tools, implements, etc., the Hawaiians surely measured up to a high potential in productivity, beyond which they moved to make even the most utilitarian articles pleasing to the eye.

Somehow, in all of this, it is difficult to reconcile the institutions of warfare and human sacrifice to the general impression one gets of these people as a whole.

To hazard a guess of a general nature, perhaps war served to drain off, collectively, mounting tensions and accumulations of hostile and aggressive impulses. Psychologically, this condition exists in individuals—an alternation of tension and release to maintain equilibrium. Can this too be ascribed to group situations?

On the other hand, there had always been a great deal of war in Polynesia, which probably was a tremendous factor in the migrations in the Pacific, influenced no doubt, in part, by population and subsistence problems. Armed aggression would seem to have evolved from a very basic

human impulse to survive which in the course of time had taken on many secondary functions. On the surface here it apparently was tied in with the concentration and holding of power in terms of government rule which on account of consanguinity of leaders grew in complexity and frequency.

Religion was an essential part of the culture of the Polynesians, and so, of the Hawaiians. Doubtless, it evolved from a deep need to answer in some way the imponderables of existence—the supernatural, the immortality of man, etc. An intangible, created with the mind, it brought happiness, comfort, and security in the face of the unknown just as material things made with the hands evolved as means to deal with the mundane needs of subsistence. Additionally, it served as a suppressive force. Every society is bound to impose some restraints on its members, and here the regulations were more or less external, in the nature of taboos. Associated primarily with religion, the taboo set up a system of controls pertinent to other aspects of the culture as well, and had its function in that it kept people in line. When suppression is the chief mechanism of control, regulations, nevertheless effective, are less omnipresent and all-pervasive. Control is imposed from without rather than within, which to an extent leaves the individual unshackled by mental chains and crippling inhibitions. Does this not explain in part perhaps that equanimity, that "inner freedom of spirit" so characteristic of the Hawaiian?

In concluding, a few words might be said in relation to physical environment, per se, as it may have reflected in the personality of the Hawaiians.

Climate surely was a factor. With relatively little occasion to fight the untoward forces of nature in maintaining subsistence, time could be devoted to other pursuits. The Hawaiians' skill as navigators, their remarkable engineering feats, art of carving, fiber and feather work, and the beauty of their myths and legends lends credence to this assumption. It has been said that the benign climatic conditions of the Mediterranean area had much to do with the progress and development of ancient Greek civilization. Time for philosophic reflection and expression of creative artistic impulses was made possible when the requirements for living did not impose too rigorous a task on the people. Where nature is benevolent and bounteous, it cannot but reflect in those who are objects of her benevolence and bounty.

To a wide variety of terrain can be assigned some significance in terms of the ingenuity of the people. This is apparent in the intelligent management and development of arable lands, and in the utilization of various indigenous products of mountain, lowland, and sea.

While natural resources were limited to a degree (chiefly there being no metals), substitutes were abundant, the usefulness of which was exploited in a wise, intelligent and productive manner.

The geographic isolation of Hawaii was not without advantage. It provided a very real sense of security; remote from other inhabited lands there was little danger or possibility of molestation by invading peoples. In this little island stronghold they were secure and deeply entrenched. With a self-sustaining, highly developed economy, recipients of natural bounty providing a not too rigorous, harsh way of life, a group with a common origin and universal culture patterns—they were indeed a remarkable people.

This, an old Hawaiian proverb, gives in a few beautiful words and even more beautiful thought, the essence of the spirit of the old Hawaiian:

"He lani ko luna, a he honua ko lalo." "The heavens above us and the earth beneath—that is the whole of life. All else is unimportant."

## TUBERCULOSIS CONFERENCES

The Tuberculosis and Health Association of the Territory of Hawaii is sponsoring conferences in Maui, Hawaii, Kauai, and Oahu on patient services this spring. The dates for the conferences are:

Hawaii—March 30, 31 and April 1
Maui—April 6, 7 and 8
Kauai—April 13, 14 and 15
Oahu—April 20, 21 and 22

The Territorial Planning Committee will hold a Summary Conference in Honolulu on April 23 and 24. At this session, the reports from the county conferences will be reviewed and prepared for publication. Plans will also be made for following up the recommendations of the conferences. Local Planning Committees in each of the counties have been preparing for these conferences for several months. Miss Agnes Gerding, Associate, Program Development of the National Tuberculosis Association met with the Territorial Planning Committee in Maui in January. The National Tuberculosis Association will supply the following consultants:

Holland Hudson, Director of Rehabilitation Services
Oscar Turk, Associate in Social Work
Mrs. Elizabeth Jordan, Associate in Health Education
Miss Agnes Gerding, Associate in Program Development

Both lay and professional people who are interested in the tuberculosis program in the Territory are invited to attend these conferences. The chairmen for the conferences are as follows:

Hawaii: Mrs. Myrtle Ward
Miss Margaret Barnett, Co-Chairman
Maui: Jack Crouse
Kauai: Miss Myrna Campbell
Oahu: Dr. Robert H. Marks
Territorial Conference: Tate Robinson
Dr. Robert H. Marks, Co-Chairman

*The purpose is to explore possible ways in which we might aid the patient to return to the community as a productive citizen by*:

a. Developing a better understanding of the social, economic, and emotional problems created by TB for patients, families, and communities;
b. Studying means of encouraging patients to use their personal resources;
c. Planning for the improvement and better use of existing facilities and services;
d. Determining the need for additional facilities and services.

## INSTITUTE IN PREMATURITY

Since prematurity is the leading cause of infant deaths in Hawaii and elsewhere, local nursing and medical societies and the Territorial Department of Health are cooperating to provide additional professional training in the care of prematures.

Miss Ethel Tschida, R.N., Supervisor of Premature Nurseries and Instructor of Pediatrics at New York Hospital, will be in Hawaii during the month of April. She will present the nursing aspects of premature care in a two-week institute in Honolulu. Shorter sessions are being arranged on the neighbor islands at the request of local nursing and medical groups. Local physicians and other professional workers are assisting with the Honolulu program, which will be held in the Mabel Smyth Lanai. Supervised practice and observation will be arranged in Honolulu premature nurseries for nurses requesting it.

It is hoped that every hospital will take advantage of this opportunity for special training of doctors and nurses in meeting the problems of caring for premature infants.

Scheduled from 1-5 p.m. April 6 through 17, the Honolulu institute will offer the following sessions:

1. Planning for Premature Care
   The role of statistics and socio-economic factors.
   Mrs. L. L. Yee, social worker; Dr. K. Edgar and Miss Tschida.
2. Prevention of Prematurity and Obstetrical Aspects
   Dr. McCorriston, Miss Tschida, Mrs. Abel, nutritionist.
3. Care at Delivery and Nursery Admission
   Dr. G. Ewing, Dr. C. Kobayashi, and Miss Tschida.
4. Physiology, Medical Aspects and Common Medical Problems
   Dr. T. Yoshina, Dr. J. Palma and Dr. M. Hasegawa.
5. Principles of Nursing Care
   Miss Tschida.
6. Premature Care in Small Hospitals
   Dr. J. Reppun, Mrs. F. Alexander, Miss Tschida.
7. Parent Education, Home Care on Hospital Discharge
   Parent-child relationships
   Miss Claire Canfield.
   Other participants to be arranged.
8. Mental and Physical Development, Prognosis, and Medical Followup
   Lt. Col. Currance, Dr. D. Marshall and Dr. Francis Chu.
9. Consideration of Handicapping Conditions Related to Prematurity
   Dr. W. Wong, Dr. A. Connor, Dr. L. T. Chun.

The Honolulu County Medical Society is sponsoring two evening sessions on prematurity at which hospital administrators and nurses will be their guests. Obstetrical aspects will be considered on the first evening and pediatric problems on the second.

## STUDY OF TUBERCULIN TESTING, KAUAI, TERRITORY OF HAWAII

Early in March a study on use and value of tuberculin testing is to be initiated on Kauai.

Dr. Carroll Palmer, Medical Director, Field Studies Branch, Division of Tuberculosis, Public Health Service and member of Tuberculosis Research Office, World Health Organization, Copenhagen, Denmark, set up the framework for the project on a recent visit to the islands.

Present plans are to send out, from the Public Health Service, a team of two technicians, who have done extensive testing in the United States and in India. They will test kindergartners and first graders.

The two major objectives of the study are: (1) to discover undiagnosed cases because usually children in this age group with positive tuberculin reactions have acquired the infection in their own homes, and (2) to determine the amount of non-specific tuberculin sensitivity present here. In his work with WHO, Dr. Palmer has tested a tremendous number of people in many parts of the world, and has found that this non-specific reaction (the so-called equivocal reaction or "false positive") is present in some places and absent in others. While it is thought that non-specific re-

actions do not occur here, study will serve to validate the assumption.

Beyond providing a focal point for intensive search of source cases among positive reactors, epidemiological study will help to determine the trend of tuberculosis here and to delineate areas where more intensive work may be needed.

Plans are being made also for the visiting technicians to conduct institutes or demonstrations for local people in an attempt to standardize and improve tuberculin testing techniques throughout the islands.

## FETAL DEATH STUDY, KAUAI, TERRITORY OF HAWAII

This investigation is one of a number of cooperative projects between the School of Public Health, University of California, and selected State or Territorial Departments of Health of the Western Region of the United States.

The study to be conducted on Kauai is for these purposes:

1. To determine incidence of fetal deaths at individual months of pregnancy.
2. To investigate medical, social, and environmental factors in fetal mortality.
3. To evaluate the feasibility of implementing the WHO definition of live birth and fetal death.
4. To provide data bearing on association between length of gestation and birth weight in different racial groups.
5. To develop methods useful in longitudinal studies of pregnancy.

The main feature of the study consists of the identification, early in their pregnancy, of all the women on the island who are pregnant at a given time, and to follow those women through pregnancy to its termination, and finally to follow the live births through their first year of life.

The specific steps in the process are: the 7-8000 households on the island will be visited by special interviewers, who will obtain information from all women of child bearing age on their previous reproductive history and as to their pregnancy status at the time of interview. Attempts will be made to notify the project if and when they become pregnant. Sample interviews to date indicate that such cooperation can be expected on the island. Local physicians have agreed to notify the project as soon as women register with them for prenatal care. Public health nurses similarly will alert the register of any pregnant woman of whom they have knowledge living in their districts.

Data to be collected will relate to social, economic, and environmental conditions, medical information on the course of pregnancy, delivery, and post-partum period, the termination of pregnancy, and data on the live born infant at birth, and through follow-up activities, their status during the first year of life.

The field personnel will be employed by the Department of Health, Territory of Hawaii, and will function under the administrative supervision of the Bureau of Maternal and Child Health and Crippled Children, technical direction provided by the Maternal and Child Health Research Unit of the School of Public Health, University of California. Public health nurses on the island will assist in the work, primarily in terms of follow-up during infant's first year of life.

As is known, the leading cause of infant death is prematurity, and factors causing prematurity are not too clearly defined. Results from such a study might well point toward some of these factors, thus enabling doctors to look then for means of dealing with them.

## WORKSHOP: AUDIO-VISUAL AIDS

On November 14, at the Honolulu YWCA, Professor Joseph S. Smith, Chairman, Speech Department, University of Hawaii, spoke at a Workshop on Audio-Visual Aids.

Since his subject, "Speaking with a microphone" is a problem with which most of us must deal on occasion, it seems worthwhile to pass on the highlights of his discussion.

Dr. Smith suggested, first of all, that a public address system never be used unless it is necessary, particularly by the inexperienced. It tends to inhibit the novice, for it limits him spatially and does not permit much physical freedom.

He advised that, for best results, the microphone be tested before use. They differ in sensitivity, picking sound variously from one side, two sides, and in some cases on all sides. Then having found the "beam" it is important that the speaker remain in that area rather than move about. Eighteen inches from the microphone is considered ideal distance. It is better to stand away and speak up, otherwise extraneous sounds such as breathing, swallowing, tongue sticking, etc. are picked up.

Care should be taken also that the microphone does not block the face. Adjusted to the level of the mouth the audience can see the speaker and the speaker, the audience, which makes for better response.

Manuscripts create difficulty, the larger the paper the more difficult to hold. Additionally in turning papers the sound is apt to be picked up

and amplified. Rather than ordinary paper for notes Dr. Smith suggested use of folded 8½ x 11 size paper or 5 x 8 cards since short lines of words are easier to follow and one is thus less apt to lose his place.

## INDUSTRIAL NURSING SEMINAR

During January of this year the Territory was fortunate in having the services of Miss Winifred Devlin, industrial nursing consultant, Division of Occupational Health, USPHS. Her visit was sponsored jointly by the Honolulu Chamber of Commerce, the Territorial Department of Health, and the USPHS. In addition to offering individual consultation to industrial nurses, she conducted seminars in Honolulu and Maui primarily for the nurses employed in industry.

The general objective of the seminars was to consider the responsibilities of and the demands made upon the nurses in the development of occupational health programs, to explore the view points and problems of management and labor groups and community health and social agencies and the nurses' relationship to each group.

The topics covered included the new developments in occupational health programs, administrative relationships to management and clarification of policies for industrial nursing service, establishment of nursing policies and procedures, inter-department coordination, use of community health resources, industrial health records and reports, criteria for the evaluation of existing industrial nursing services, and criteria to assist in determining the need for nursing services in a given industry.

The seminar in Honolulu recommended that the industrial nurses formulate professional standards for industrial nursing practice in the Territory, that a proposed program be formulated for orientation of the newly employed industrial nurse, that an industrial nursing consultant be employed by the Territorial Department of Health, that industrial nursing be included in the curricula of the schools of nursing.

## AMENDMENTS TO CONSTITUTION AND BY-LAWS, NURSES' ASSCOCIATION, DISTRICT OF OAHU

The Board of Directors of the Nurses' Association, District of Oahu, voted at their board meeting held on January 26, 1953, to publish the amendments to the Constitution and By-laws of the Association as accepted at the annual membership meeting held on January 5, 1953.

Any member desiring a copy of the recently revised Constitution and By-laws may secure same by calling the NADOO office, telephone 522255; otherwise no copies will be mailed to the members.

All new members receive a copy of the Constitution and By-laws.

Amendments are as follows:

Page 1, No.4:

To read: "Registered professional nurses are eligible to membership in this association."

Delete: "residing or practicing in this district."

Page 2, ARTICLE I, Section 3:

To read: "Associate members shall have the following privileges:"

Delete: "the same privileges as active members as follows:"

Page 3, ARTICLE I, Section 7:

To read: "Membership shall be granted upon approval of credentials and payment of dues."

Delete: "Election to membership shall be by written secret ballot by the active membership of the association and three (3) negative votes shall exclude from membership. Any applicant who has been excluded may re-apply for membership."

Page 8, ARTICLE VIII, Section 1-A:

To read: "The annual dues for active members of the Nurses' Association, District of Oahu shall be twenty-two dollars ($22.00) payable on or before March 1. These dues include ten dollars ($10.00) for Nurses' Association, Territory of Hawaii, Inc., five dollars ($5.00) American Nurses' Association, two dollars ($2.00) Nurses' Inter-Island Bulletin, one dollar ($1.00) Nursing Service Bureau, and four dollars ($4.00) Nurses' Association, District of Oahu. Active members who have not paid dues by March 1 shall be so notified by the association and those who have not paid dues by March 15 shall be dropped as members. Dues may be paid in installments not to exceed three (3) and installment payments should be completed within three (3) consecutive months."

Delete: "The annual dues for active members of the Nurses' Association, District of Oahu shall be twenty-one dollars ($21.00) per capita, payable on or before February 10. These dues include seventeen dollars ($17.00) per capita to the Nurses' Association, Territory of Hawaii, Inc. Of this amount three dollars ($3.00) per capita is forwarded to the American Nurses' Association. Dues paid after February 10 will be considered delinquent and a delinquent fee of one dollar ($1.00) will be charged on all such delinquent dues. Active members who have not paid dues by February 10 shall be notified by the treasurer and those who have not paid dues by March 15 shall be dropped as members."

Page 8, ARTICLE VIII, Section 1-B:

To read: "The annual dues of the associate members of the Nurses' Association, District of Oahu shall be five dollars ($5.00) per capita payable on or before March 1. These dues include two dollars and seventy-five cents ($2.75) per capita to Nurses' Association, Territory of Hawaii, one dollar and twenty-five cents ($1.25) per capita to the American Nurses' Association. Associate members who have not paid dues by

March 1, shall be notified by the association, and those who have not paid dues by March 15 shall be dropped as members. Dues for associate members who become active members during any fiscal year and who have paid dues as associate members for that year will pay seventeen dollars ($17.00) to the Nurses' Association, District of Oahu, of which amount fifteen dollars and twenty-five cents ($15.25) shall be to the Nurses' Association, Territory of Hawaii, Inc. Of this amount Nurses' Association, Territory of Hawaii, Inc., will send the American Nurses' Association three dollars and seventy-five cents ($3.75), one dollar ($1.00) to Nursing Service Bureau, two dollars ($2.00) to the Inter-Island Bulletin."

Delete: "The annual dues of the associate members of the Nurses' Association, District of Oahu shall be five dollars ($5.00) per capita payable on or before February 10th. These dues include two dollars and seventy-five cents ($2.75) per capita to the Nurses' Association, Territory of Hawaii, Inc. who will send seventy-five cents ($.75) per capita to the American Nurses' Association. Dues paid after February 10th will be considered delinquent and a delinquent fee of one dollar ($1.00) will be charged on all such delinquent dues. Associate members who have not paid dues by February 10th shall be notified by the Treasurer and those who have not paid dues by March 15th shall be dropped as members. Dues for associate members who become active members during any fiscal year, and who have paid dues as associate members for that year, will pay sixteen dollars ($16.00) to the Nurses' Association, District of Oahu, of which amount fourteen dollars and twenty-five cents ($14.25) shall be paid to the Nurses' Association, Territory of Hawaii, Inc. Of this amount the Nurses' Association, Territory of Hawaii, Inc. will send two dollars and twenty-five cents ($2.25) to the American Nurses' Association."

Page 8, ARTICLE VIII, Section 2:
To read: "Eighteen dollars ($18.00)" instead of "seventeen dollars ($17.00)."

Page 8, ARTICLE VIII, Section 3:
To read: "Former active or associate members—application for current membership must be accompanied by an application form and payment of dues."

Delete: "Former active members and/or associate members whose dues have lapsed and who have been dropped from membership may be reinstated by a majority vote of the Association upon payment of dues for the current year and a reinstatement fee of one dollar ($1.00)."

Page 9, ARTICLE IX, Section 4:
To read: "Notice of meetings shall be sent to the membership ten (10) days in advance."
Change "one week" to "ten days" and delete "and ten (10) days in advance in the case of special meetings."

Page 9, ARTICLE IX, Section 5:
To read: "The order of business at regular meetings *may* be."
Change "shall" to "may be."

Page 9, ARTICLE IX, Section 6:
To read: "The order of business at the annual meeting *may* be:"
Change "shall" to "may be."

Page 10, ARTICLE X, Section 4:
To read: "Officers to *a* section, etc."
Change "the" to "a."

Page 10, ARTICLE XII, Section 1:
To read: "Five (5) officers and forty (40) members shall constitute a quorum at any meeting of the association."
Delete: "regular."

Page 10, ARTICLE XII, Section 2:
Delete: "Seven (7) officers and (80) members shall constitute a quorum at any annual or special meeting."

Page 11, ARTICLE XV, Section 2:
To read: This constitution and these By-laws, etc., etc.

## INTERNATIONAL CONGRESS OF NURSING

Ella Best, R.N., Executive Secretary of ANA, chosen Public Relations Chairman of I.C.N. Tenth Quadrennial Congress, asks that note be taken of change in location of the Congress. It will be held at the Hotel Quitandinha, Petropolis, Brazil (45 miles from Rio de Janeiro), from July 13 to 17, inclusive, 1953.

The Brazilian Graduate Nurses' Association will arrange all accommodations, either in the Congress Hotel or at an adjacent hotel in Petropolis. Minimum price for board and lodging arranged by Brazilian G.N.A. will be at the rate of ten (U.S.) dollars per day. Congress participants who prefer to stay in Rio de Janeiro must reserve their own accommodations through a travel agent. A regular bus service runs between Rio de Janeiro and Petropolis. The trip takes approximately one-and-a-half hours.

The Congress registration fee, payable on arrival at the Hotel Quitandinha, will be five dollars per person.

## JOB OPPORTUNITIES

Atomic Bomb Casualty Commission needs a bilingual (English and Japanese) nurse, who has sufficient theoretical and practical experience in nursing supervision and administration to assume a responsible position. It is suggested that anyone interested contact Miss Leona Adam, Counselor, Counseling and Placement Service, NATH, 510 S. Beretania Street, Honolulu.

* * *

Summer jobs are available each year in Girl Scout established camps in all sections of United States. Salary plus maintenance with the opportunity to work with congenial adults and small groups of young people would make for a refreshing change of pace and surroundings. For further information write Nancy Lawrence, Director, Recruitment Promotion, Public Information Division, National Headquarters, 155 East 44th Street, New York 17, New York.

## BOOK REVIEWS

### *Interpersonal Relations in Nursing*

By Hildegard E. Peplau, R.N., 309 pp., Price $5.00, G. P. Putnam's & Sons, New York, 1952.

This book tries to assist nurses, both graduate and student, to be more effective in our relationships with patients and co-workers.

It is divided into four parts which include Part I, Phases and Roles in Nursing Situations, Part II, Influences in Nursing Situations, Part III, Psychological Tasks, Part IV, Methods for Studying Nursing as an International Process.

Part I relates first the author's definition of nursing. Frequent diagrams are found throughout the first part as well as in the other parts to illustrate the author's point of view more vividly. Following the definition the nurse's role is then divided according to the patient's stay in the hospital beginning with the orientation. To conclude the first part we as nurses are made to realize the many roles we play.

Part II finds us meeting the needs and wants of our patients even when the need or want cannot be clearly defined by the patient himself. Patients are fearful without an available explanation. Through our interpersonal relations we may alleviate this fear and replace it with security.

Part III deals with studying the degrees of skill which we exercise in working with people by fulfilling our patients' needs. We must remember we also gain something from the interpersonal relationship.

Part IV reveals to us the methods used to accomplish a satisfactory relationship.

The book can well be used early in our nursing schools to depict situations and their probable solutions. The young students would also realize how they can develop this skill and realize its dynamic role in nursing.

MARY FAE TOLLES, R.N.

### *Careers for Nurses.*

By Dorothy Deming, 351 pp., Second edition, Price $4.50, McGraw-Hill, New York, 1952.

As the title implies, this book contains up-to-date information on nursing careers and is a systematic investigation of job opportunities available in nursing. This edition can be very helpful to counselors in secondary schools and junior colleges as well as to students of nursing.

This revision retains the original aim of assisting professional nurses to select their specific fields of nursing comparable to their special interests and abilities, to attain the qualifications necessary, and to continue to grow professionally.

One of the salient characteristics is that authentic descriptions have been written by nurses in the various fields; reasons why they enjoy their specific fields and their usual nursing functions have also been included. The author then supplies additional information such as current salaries, sources of employment, and additional bibliographies. Pertinent information on applying for positions, discussion of personal interviews, and principles in resigning from positions will assist young graduates in adjusting to the profession.

There are numerous opportunities in the areas of rural nursing, psychiatric nursing and supervisory fields and the author has presented these facts in an ostensible manner.

CYNTHIA L. WOLFE, R.N.

### *Operating Room Technic.*

By Sisters of St. Francis, St. Mary's Hospital, Rochester, Minnesota, 345 pp., Fourth edition, Price $6.50, W. B. Saunders Company, Philadelphia, 1952.

This fourth revision includes detailed instructions on the set-ups for operations, step-by-step procedure of surgery and recent advances in operative procedures. A brief description of the Rochester Operating Room Suite may serve as a guide to those in planning revisions of their surgical suite plans. Although it has been written to fulfill the specific needs of St. Mary's Hospital, the basic principles are universal and this book may be considered in nursing reference libraries.

Numerous illustrations have been included to assist nurses in visualizing appropriate positions and necessary equipment for specific operations. The illustrations of the recent developments in plastic surgical procedures will be appreciated by nurse instructors. Each operative procedure is included in proper groupings and the definition of the specific operation, the correct position for the patient, the necessary sutures and the instrument set up are adequately stated. Specific emphasis has been given to the surgical team, and to the educational programs for both basic students and graduate nurses.

General principles on cleansing operative areas, sterilization and surgical drapings have not been considered as well as in other texts; yet this book is a good reference for operating room nurses.

CYNTHIA L. WOLFE, R.N.

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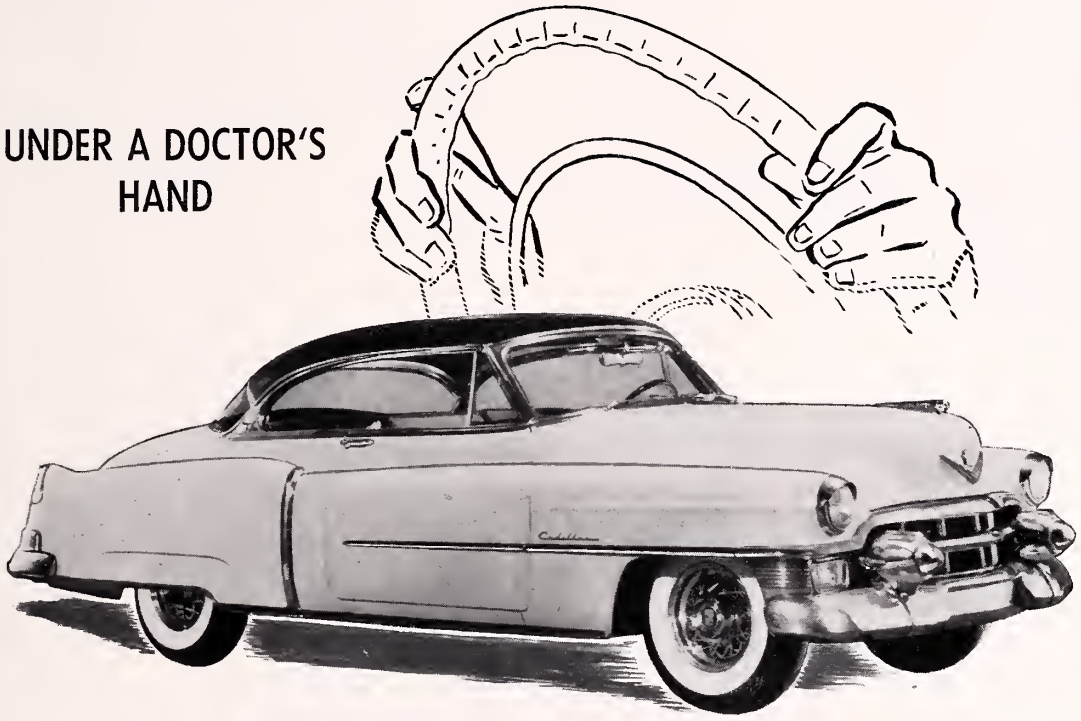
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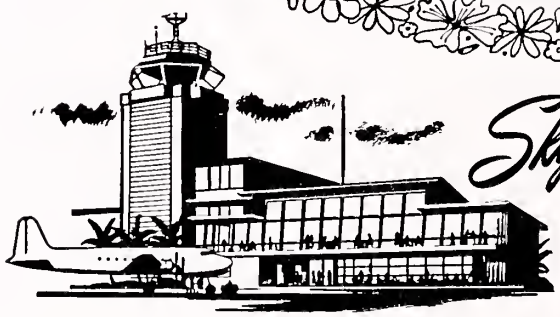


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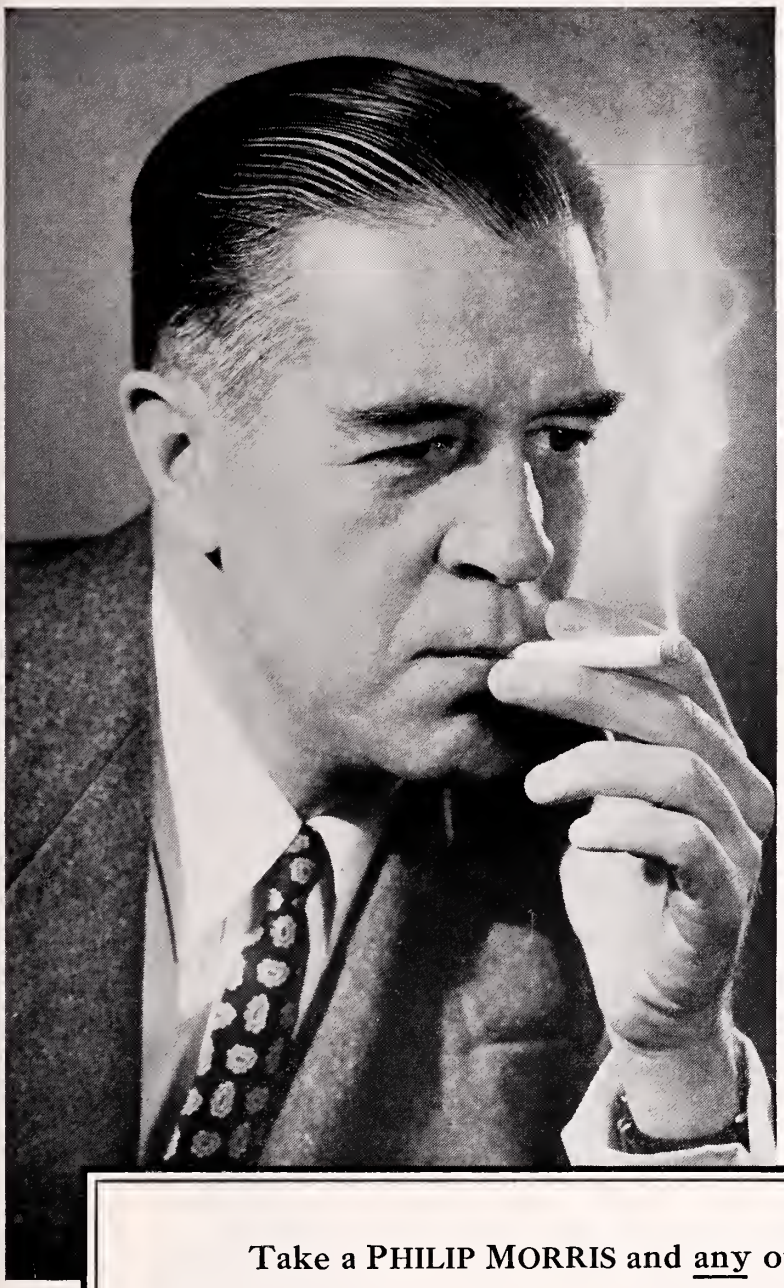
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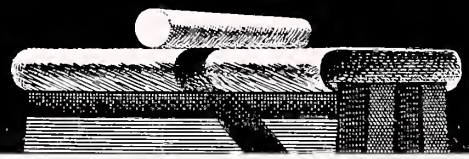
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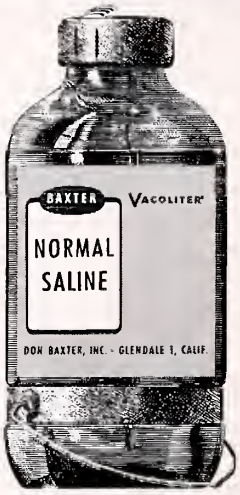


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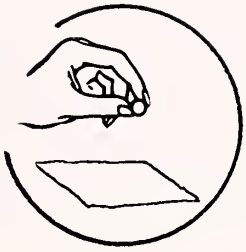
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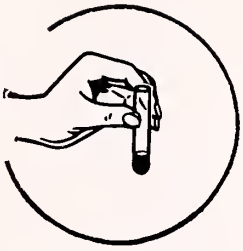
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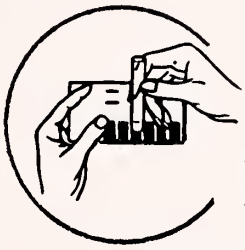
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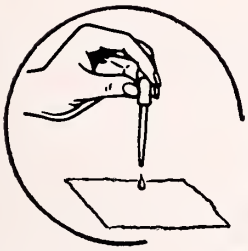
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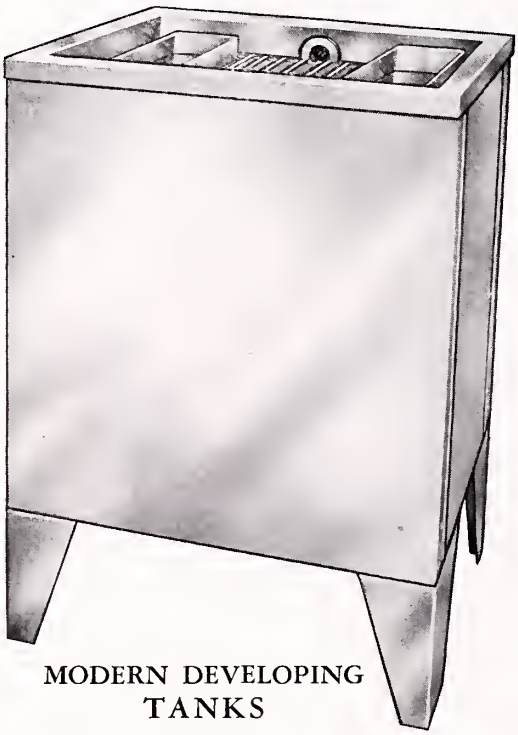
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## . . . *right through the menopause*

*on oral estrogen therapy that imparts*

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**No Taste or After-Taste**




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1. Reich, W. J., et al. (1952), A Recent Advance in Estrogen Therapy. II. American J. Obst. & Gynec., 64-174, July

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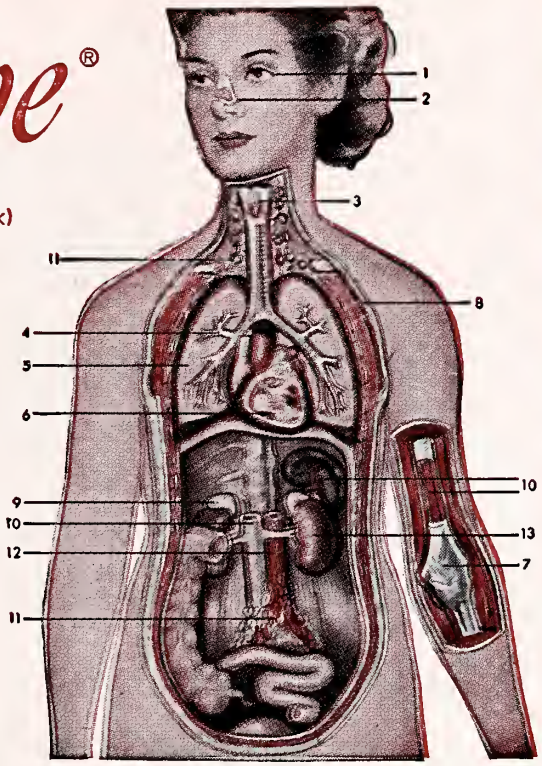
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*The many indications for* CORTONE *highlight its therapeutic importance in everyday practice*

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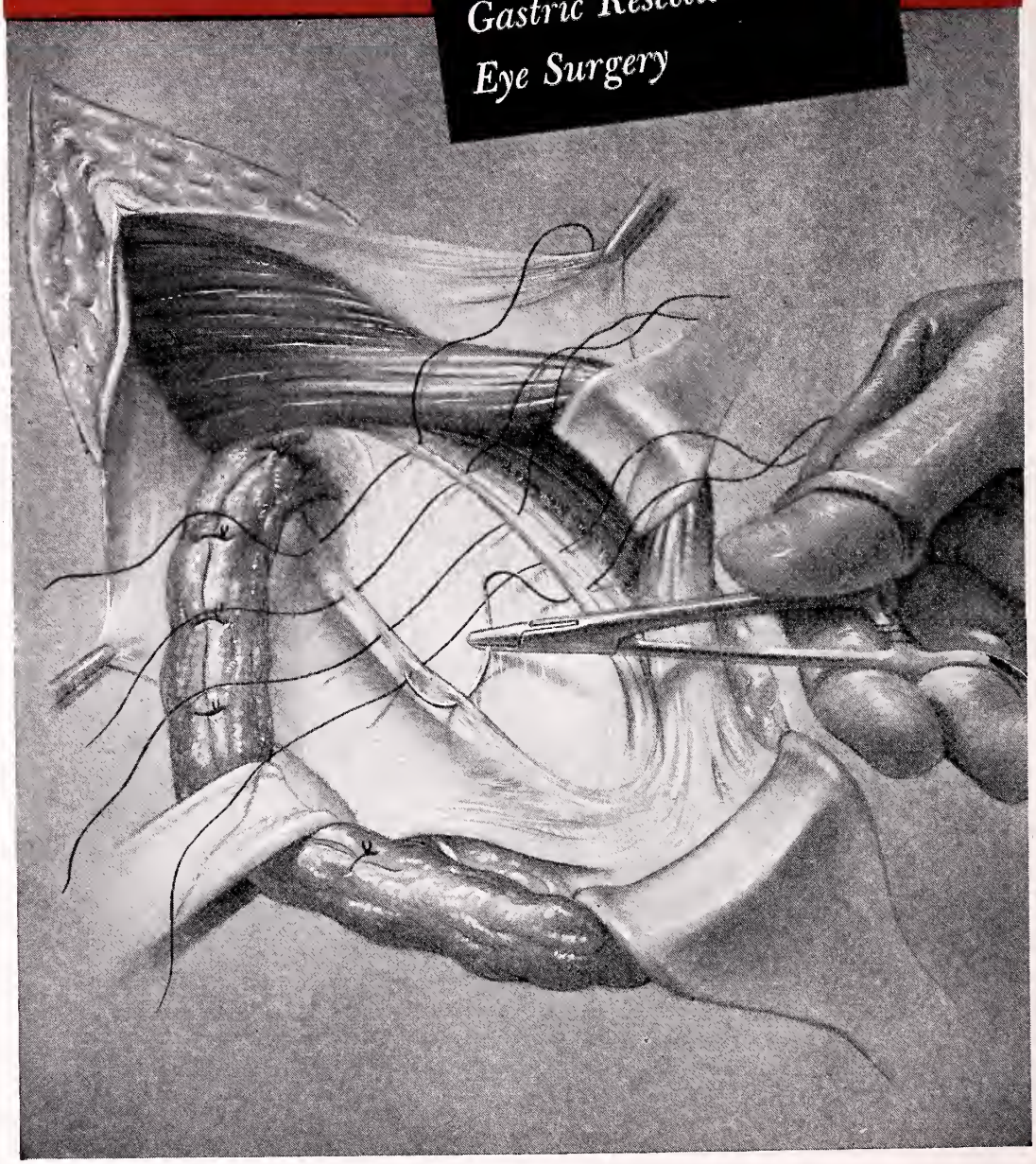
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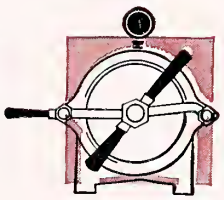
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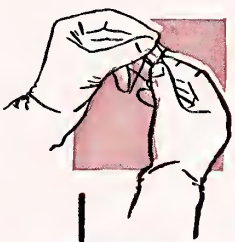
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**2** ***Withstands repeated sterilization:*** New Anacap Silk can be boiled or autoclaved ***six separate times*** without appreciable change in either strength or texture. In laboratory tests almost the full original strength is maintained even after 23½ hours of boiling.



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*Specify* 84 PROOF

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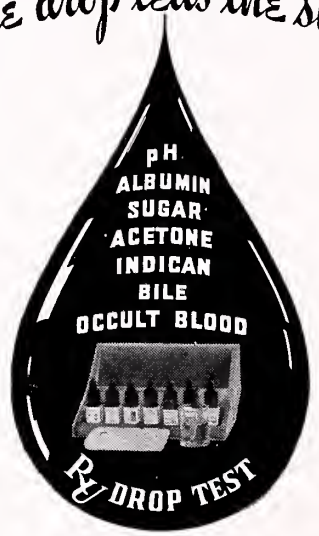
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in chest surgery...
Pre- and post-operative prophylaxis
or treatment—among the many indications
for therapy with well tolerated
Terramycin
brand of oxytetracycline,

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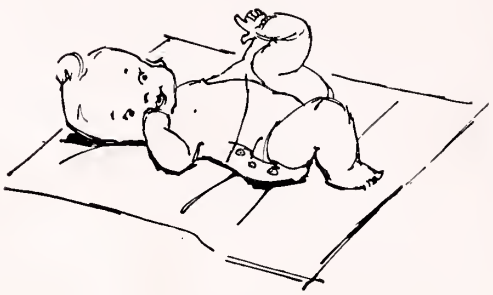


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Olac supplies milk protein in exceptionally generous amounts. Its fat, a single highly refined vegetable oil, is well tolerated and easily assimilated. Dextri-Maltose, supplementing the lactose of the milk, meets energy needs and spares protein. Vitamin A and D supplements are also included in the formula.

Olac is easily mixed with warm water—1 measure to each 2 ounces water makes a formula supplying 20 calories per fluid ounce.

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**for both full term and premature infants**






**Olac**

MEAD

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Evansville 21, Ind., U.S.A.

# HAWAII MEDICAL JOURNAL

and

## INTER-ISLAND NURSES' BULLETIN

LUE 12 MAY-JUNE, 1953 NUMBER 5


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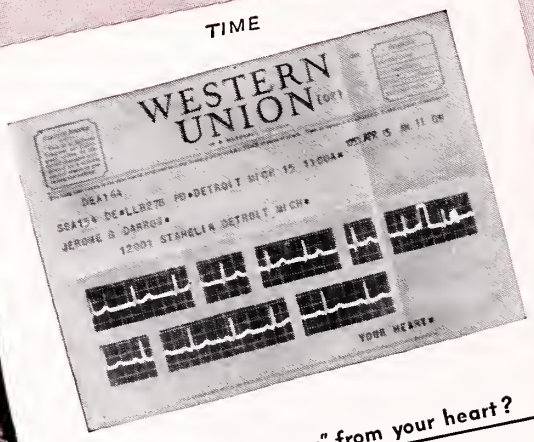




Parke, Davis & Company announces a new series

# THEME: "In the hands of yo

TIME




## Ever see a "telegram" from your heart?

**You are looking** at an *electrocardiogram* . . . a record of the tiny electrical impulses given off at each beat of your heart.

When interpreted by your doctor, such "telegrams" may read, "Patient's heart normal . . . no need for worry." Others may say "Patient's heart faulty . . . help required."

Yet, even when the heart sends out a message of trouble, it does not necessarily mean impending tragedy. For even a defective heart is capable of working for years if not overburdened.

Thousands of people are living good lives with bad hearts . . . because they acted wisely and at time.

**First, they did not ignore** the warnings that often precede heart trouble—shortness of breath, pains in the chest, irregular beating of the heart, and constant fatigue. They heeded these warnings in time . . . knowing that their greatest security depended on taking prompt advantage of the help which medical science could give them.

Second, they accepted the limitations and restrictions imposed by a weakened heart. They tried not to "over-do"; they learned to avoid sudden exertion, and to keep weight at the normal level. They also recognized the value of sleep and relaxation, and the importance of freeing their lives from worry and strain.

**Remember** that in your physician's hands, you are in good hands. For today, heart and control equipped than ever before to treat against it as well By taking advantage of the help your doctor can give you now, you increase your chances of living a good life with a bad heart.

PARKE, DAVIS & CO.

SATURDAY EVENING POST



**This man is his own worst enemy!** Yet most of us can sympathize with him—for most of us don't "run to the doctor" every time we have an ache or pain.

We're much more likely to say "Oh, I'm all right. It's really nothing." Or to tell ourselves "I'm too busy . . . haven't time to bother with doctors."

Yet, the man (or woman) who ignores seemingly minor symptoms often runs the risk of inviting much more serious ailments. That's because most diseases thrive on neglect; the worst thing we can do is to ignore warning symptoms until it may be too late for the doctor to help.

Medical research in America today is writing one of the most heart-warming chapters in the story of mankind. Our great laboratories, our hospitals, universities and clinics, our governmental and private organizations are cooperating as never before to improve our chances of living a longer, healthier life.

Your own doctor has at his disposal all of the discoveries, all of the knowledge, of modern medical science. But you are the only one who can put these vast resources to work to help you.

So next time you are tempted to ignore warning symptoms, remember that your greatest danger lies in neglect and delay. Remember—in your physician's hands, you're in good hands. But only by acting promptly can you take advantage of the help he can give you now.

*This message is published in the public interest by Parke, Davis & Company.*
*Since 1866, physicians have prescribed and pharmacists have dispensed medicines bearing the Parke-Davis label.*

PARKE, DAVIS & CO.

LIFE

## DO YOU KNOW THIS MAN?

HIS NEGLIGENCE IS CAUSING THOUSANDS OF DEATHS FROM HEART DISEASE



*Here's a description of the culprit:*

Overweight. Short of breath. (The old ticker really pounds on a flight of stairs.)

Often over-exercises on week-ends after a sedentary week. Sometimes bothered by a peculiar swelling in the ankles.

Works too hard. (Feels he's indispensable in his job.) Has trouble relaxing. Worries. Sleeps poorly. Complains of being "always tired."

Had a couple of attacks of "indigestion" recently. When asked by wife to please check with doctor, was heard to reply: "What for? I'm not sick . . . besides I'm too busy!"




**The greatest problem** in dealing with heart disease today is the man (or woman) who ignores the "danger signals" until it may be too late to take advantage of the help which medical science today is prepared to give. Yet thousands of people are living good lives with bad hearts . . . because they acted wisely and in time . . . because they knew that in their physicians' hands they were in good hands.

For it is a fact that much progress has already been made in dealing with heart ailments, and more and more research is being carried on, largely through such great agencies as the American Heart Association and its nation-wide chapters, the National Heart Institute, and a number of pharmaceutical companies, including Parke, Davis & Company, since 1866 makers of medicines prescribed by physicians.

PARKE, DAVIS & CO.

# rtisements addressed to the general public . . .

# ysician, you're in good hands"

ct . . . delay. How many times, doctor, have you for patients . . . whose hope of recovery might been bright indeed . . . *but for neglect or delay in g your help?*

doubtedly, this occurs so often . . . and usually with ragic consequences . . . that many physicians view ne greatest problem facing medical science today.

reover, this problem may assume even greater cance with the rising incidence of the degenera- seases. For in these conditions, neglect and delay, ı well know, are *directly* responsible for a heavy life.

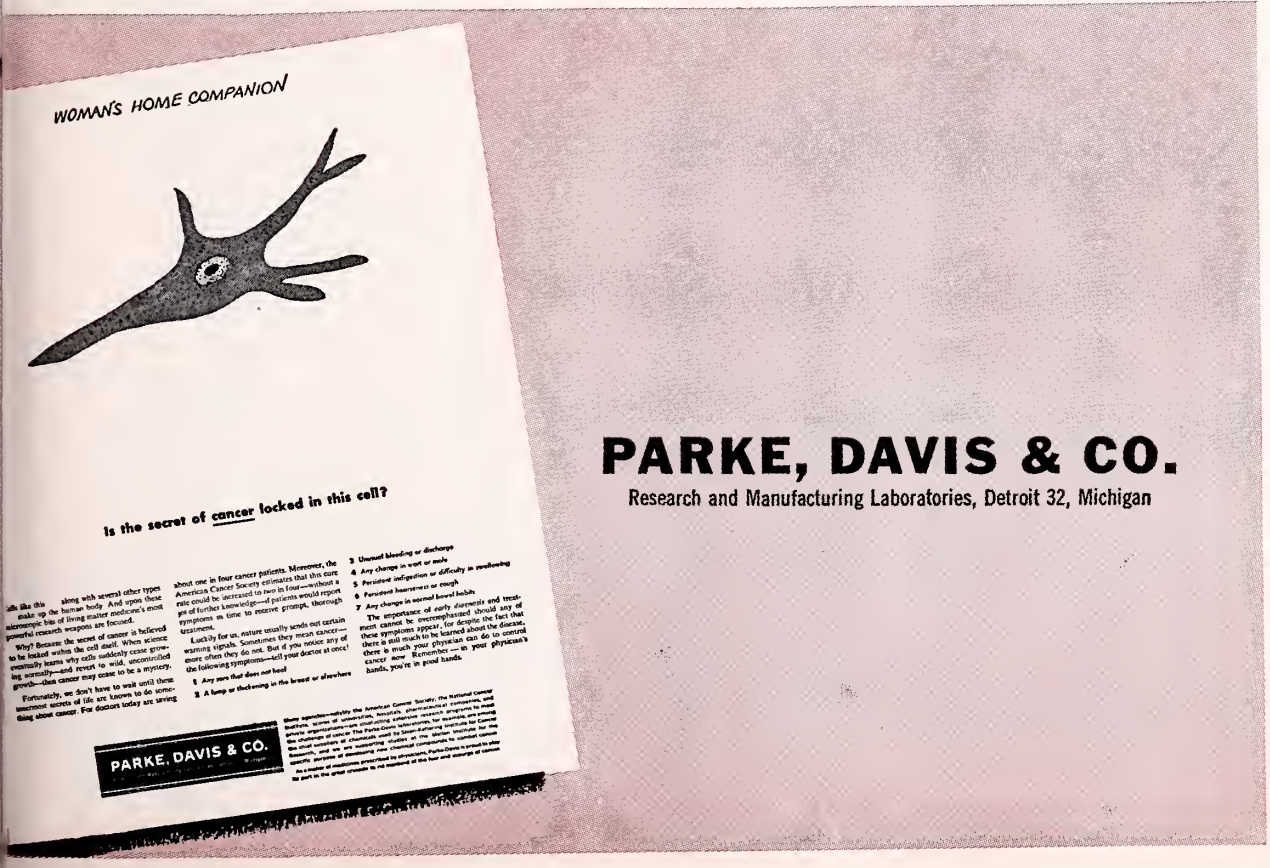
believe you will agree that this problem deserves sed and continuing emphasis. This is why Parke- will publish, throughout 1953, a series of adver- nts on the *patient's responsibility* in medical care.

se advertisements, four of which are reproduced will appear in leading magazines reaching mil- of families. In them, this central theme will be asized:

*That every individual, if he wants his physician's most effective help,* must meet the doctor halfway. *He must not ignore symptoms, or delay treatment. He must act promptly . . . and be made to realize that "in the hands of your physician, you're in* good *hands."*

In addition, the advertisements will stress the fact that medicine has a vast store of new knowledge . . . and that this knowledge is constantly increasing through research by physicians, hospitals, public and private health organizations, and pharmaceutical companies.

A word about the preparation of these advertisements: They have been carefully written to avoid both the possibility of stimulating hypochondria and encouraging self-diagnosis. Equally important, the advertisements make no claims that might cause undue optimism or raise false hopes. We believe these are just the type of informative messages you will want your patients to read. Our efforts will be guided and encouraged by your continued interest and comments.




**PARKE, DAVIS & CO.**

Research and Manufacturing Laboratories, Detroit 32, Michigan

# HAWAII MEDICAL JOURNAL

and

# INTER-ISLAND NURSES' BULLETIN

Volume 12
Number 5

MAY-JUNE, 1953

$2.00 per year
35c per copy

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Hospital Association of Hawaii

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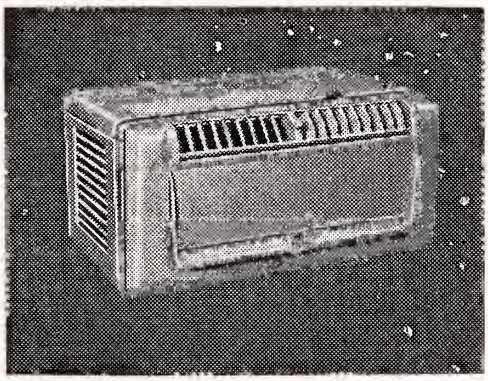
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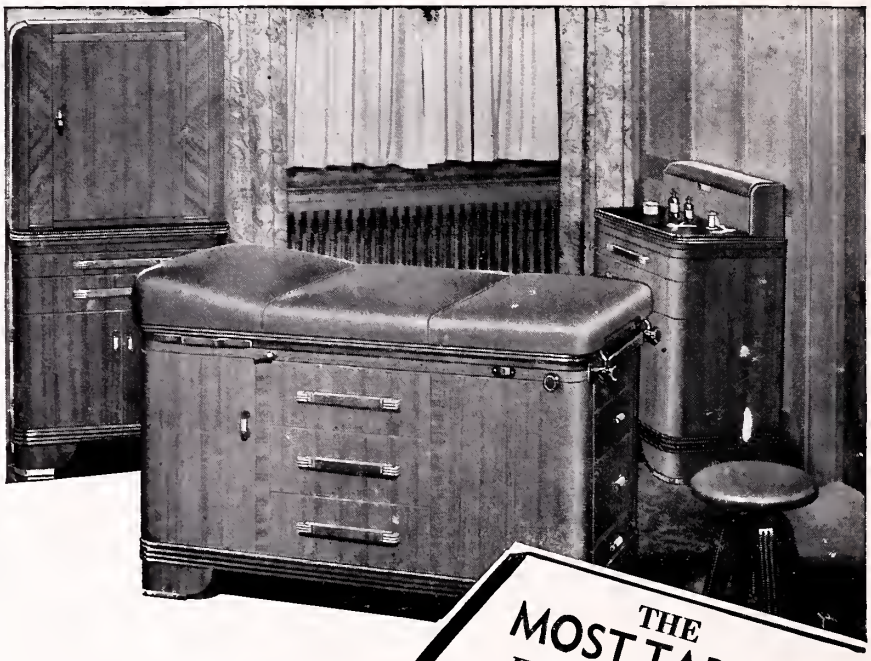
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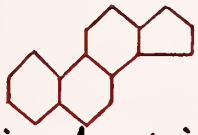
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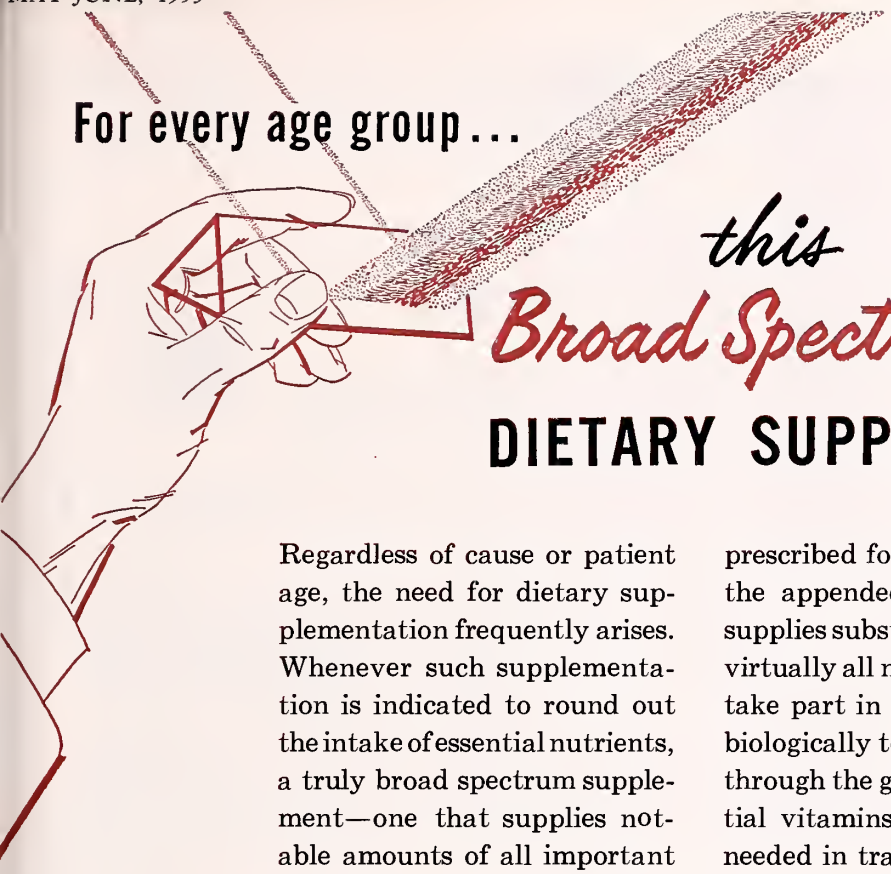
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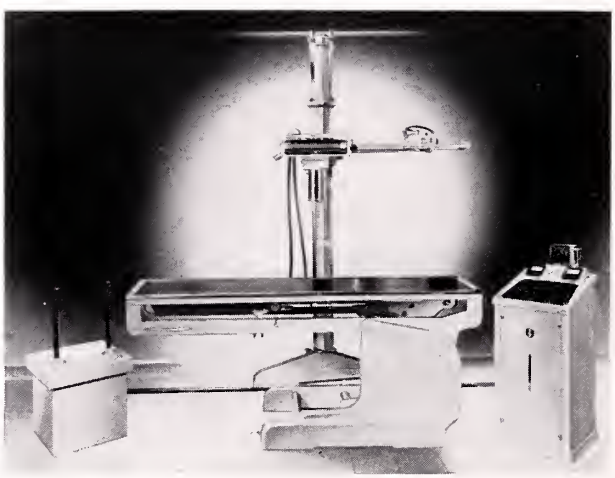
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1. Freeman, B. S., and Young, T. K., Jr.: *Arch. Surg.*, 61:1145, Dec., 1950.

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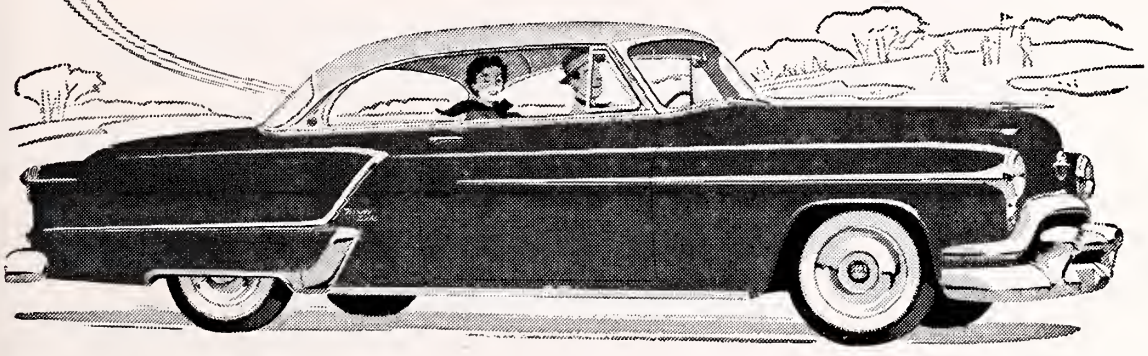
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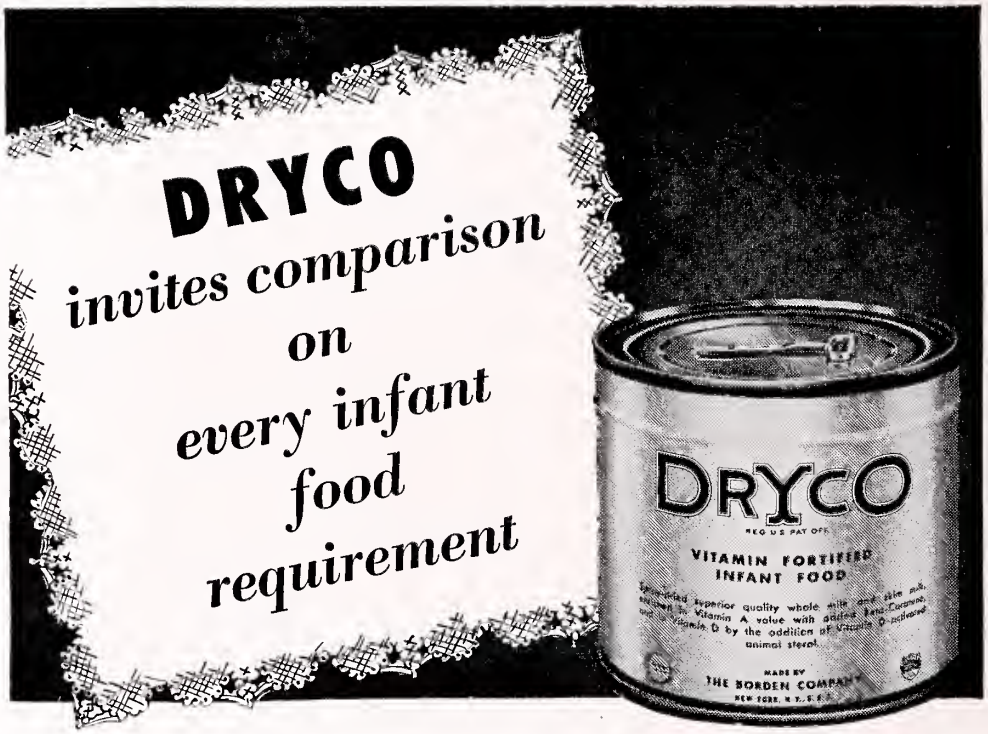
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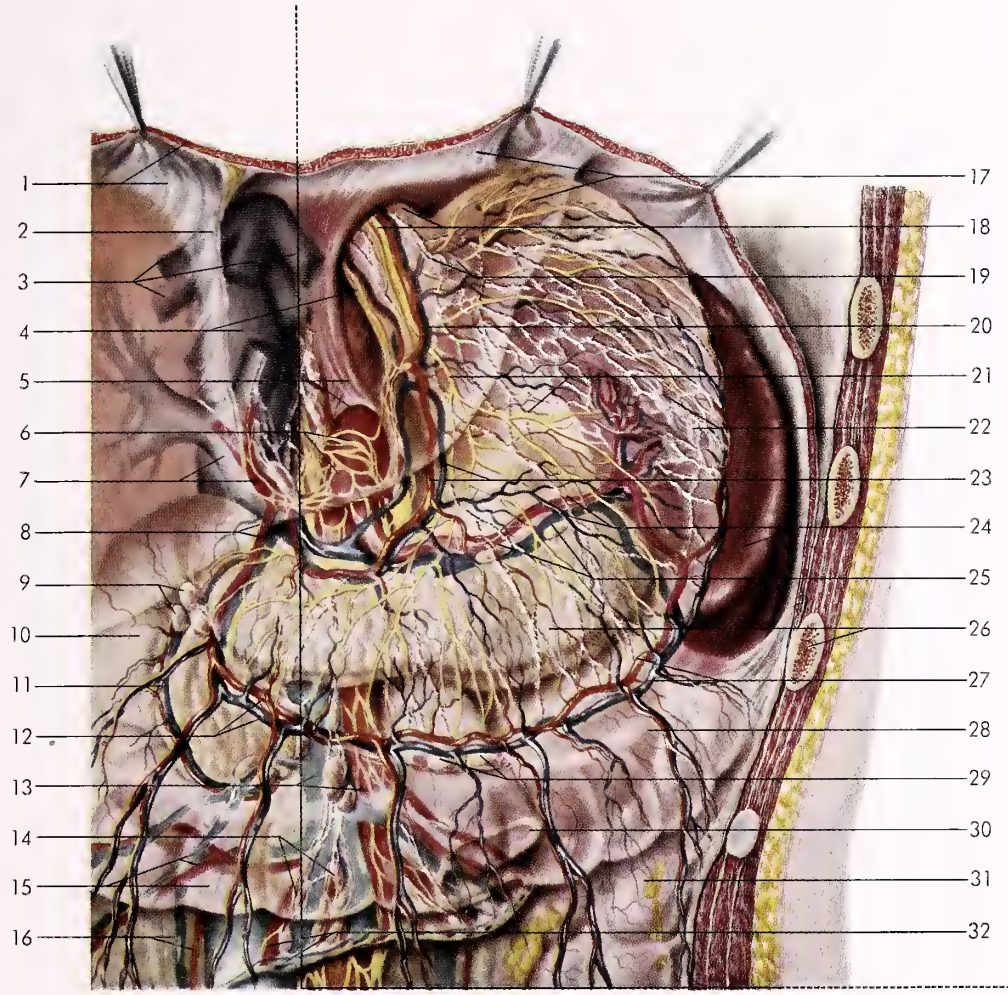
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3 Hepatic veins
4 Inferior vena cava and right vagus nerve
5 Crus of diaphragm and abdominal aorta
6 Celiac artery and celiac plexus
7 Hepatic artery and portal vein
8 Gastroduodenal artery and vein
9 Subpyloric lymph nodes
10 Duodenum
11 Superior pancreaticoduodenal artery and vein
12 Right gastroepiploic artery and vein
13 Superior mesenteric artery and vein
14 Superior mesenteric lymph nodes
15 Transverse colon and right colic artery and vein
16 Spermatic artery and vein
17 Left triangular ligament and left lobe of liver
18 Esophagus and left vagus nerve
19 Paracardial lymph nodes
20 Esophageal branch of left gastric artery and vein
21 Gastric rami of vagus nerve
22 Splenic lymph nodes
23 Left gastric artery and coronary vein
24 Spleen and splenic artery and vein
25 Superior pancreatic lymph nodes
26 Pancreas and tenth rib
27 Left gastroepiploic artery and vein
28 Left kidney
29 Inferior gastric lymph nodes
30 Jejunum
31 Descending colon
32 Ileocolic artery and vein

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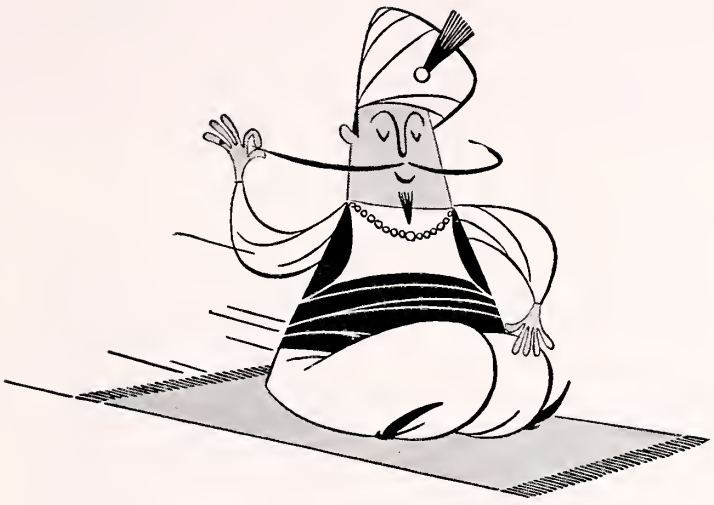
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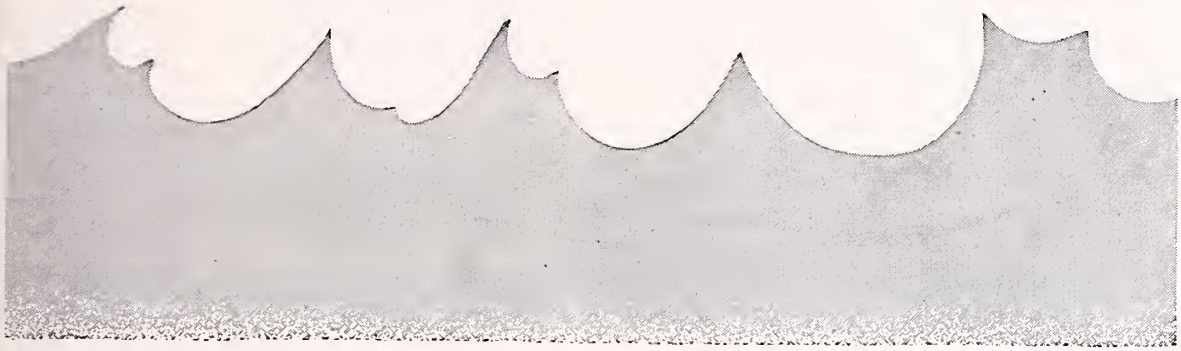
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# The Possible Existence of Clinical Toxoplasmosis in Hawaii

PAULINE GEORGE STITT, M.D.* AND MAX LEVINE, Ph.D.**
OAKLAND, CALIFORNIA HONOLULU

FOR some forty years it has been recognized that toxoplasma are parasitic on animals (Riley) but that toxoplasmosis may be a disease of human beings was not established until the pioneer investigations of Wolf, Cowen and Paige[1] (1937-42). Since then, there have been increasing numbers of cases reported in the literature.[2]



DR. STITT

The epidemiology and pathogenesis of toxoplasmosis are still obscure and the role of animals as vectors in transmission of infantile toxoplasmosis remains uncertain.[2] Foremost among natural reservoirs from which humans may acquire toxoplasma are the domestic animals, especially the dog and cat.[3]

Five types of the disease have been reported[4]: (1) an asymptomatic form in adults, detected serologically or by the birth of an infected infant; (2) encephalitis in older children; (3) an acute exanthem, resembling measles in adults; (4) chronic encephalitis in adults; and (5) infection acquired in utero.

Infection acquired in utero is capable of inflicting severe fetal damage, the organism showing a predilection for the eye and the brain, from which sites it has often been isolated. The clinical and pathologic picture varies according to the site and extent of the lesions.[4]

In the congenital form, the tetrad of deformity of the skull, convulsions, chorioretinitis, and cerebral calcifications constitutes the four most constant clinical features.[5] Feldman[6] has pointed out that the tetrad of chorioretinitis, cerebral calcification, micro- or hydro-cephalus and psychomotor retardation have been accompanied almost uniformly by serologic evidence of congenital toxoplasmosis. With the newer more sensitive serologic procedures such as the "dye test" of Sabin and Feldman[7] it has become possible to detect the disease in less extensively damaged individuals.

Diagnosis can, of course, be established by isolating the organism; but this is not always possible. Until about 1949 the only test for toxoplasmosis was the neutralization test in the rabbit's skin. Now, through the work of Sabin and Feldman,[7] there is not only a complement-fixation test[3] but a quantitative "dye test," the combination of these affording more information than either test alone.

Toxoplasmosis in children has been reported from North and South America and Europe[8] and appears to be widely distributed in the United States. Hawaii is one of the few places where proven cases of toxoplasmosis have not previously been reported.

For many years ophthalmologists in the Territory have been impressed by the high incidence of chorioretinopathy in children. In 1943, Dr. Howard Crawford of Hilo, Hawaii, interested Dr. Samuel M. Wishik, Director, Bureau of Maternal and Child Health and Crippled Children, in the subject. As a result, ophthalmologists in the Territory, the Bureau of Maternal and Child Health and Crippled Children, and the Bureau of Sight Conservation jointly assembled a list of approximately 200 cases of chorioretinopathy. An attempt was made to study these cases by skull x-rays for evidence of intracerebral calcifications. In several patients suspicious calcification was found, but further study was not undertaken owing to the lack of available laboratory tests.

Received for publication November 12, 1952.

*Formerly Chief, Bureau of Maternal and Child Health and Crippled Children, Territorial Department of Health, Honolulu, Hawaii; presently lecturer in Developmental Pediatrics, School of Public Health, University of California (Berkeley), and Senior Pediatrician, Child Development Center, Children's Hospital of the East Bay, Oakland, California.

**Chief, Bureau of Laboratories, Territorial Department of Health, Honolulu, Hawaii.

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[7] Sabin, A. B., and Feldman, H. A.: Dyes as Microchemical Indicators of a New Immunity Phenomenon Affecting a Protozoon Parasite (Toxoplasma), Science 108:660 (Dec. 10) 1948.

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In 1948 Sabin and Feldman reported on the use of dyes as microchemical indicators of the presence or absence of antibody activity.[7] This stimulated a desire to restudy the data previously assembled in Hawaii with a view to correlating them with the findings on serologic examinations of serum specimens from suspected cases. The advice of Dr. Albert Sabin was therefore sought as to the feasibility of attempting to carry out toxoplasma antibody tests in Hawaii. As a result of these inquiries, arrangements were made to submit serum specimens from suspected cases and sera of their mothers to Dr. Feldman's laboratory* at the Department of Medicine, State University of New York, Medical Center at Syracuse, a laboratory devoted especially to work with toxoplasma, for determination of toxoplasma antibody titer by the "dye test."

The "dye test" is based on the observations of Sabin and Feldman[7] that (1) whereas the cytoplasm of toxoplasma from mouse peritoneal exudate stains readily with alkaline methylene blue (*p*H 11) after contact with normal serum, this staining property is lost on exposure to toxoplasma immune serum and that (2) an adequate concentration of a heat labile (complement-like) "accessory factor," which is present in normal serum, is necessary to consummate the interaction between the antibody and organism to render the cytoplasm of the latter unstainable.

The "dye test titer" is the highest dilution of a test serum which, when in contact with toxoplasma from mouse peritoneal exudate in presence of an adequate amount of "accessory factor," renders the cytoplasm of 50 per cent of the extracellular toxoplasma unstainable with alkaline (*p*H 11) methylene blue.

Physicians of Hawaii were apprised of our interest in view of reports in the literature that (1) evidence of chorioretinitis or calcification of the skull might be associated with toxoplasma infection via the mother and that (2) toxoplasma antibodies frequently persisted for very long periods in the sera of both the affected child and the asymptomatic mother. The physicians were requested to submit serum specimens from suspected cases and their mothers to us for examination. The basis of selection was to be the presence of an ophthalmologic or central nervous system defect of obscure origin, where the possibility of congenital toxoplasmosis might arise in differential diagnosis. The physicians submitting specimens were asked to provide a case history and especially to submit any reports of x-ray examinations of the skull and evidence of chorioretinitis or other involvement of the central nervous system. Unfortunately, relatively few x-ray examinations were available, but evidence of existence or absence of chorioretinitis was reported for each case.

TABLE 1.—*Age, Physical Findings, and "Dye Test" Titers of Specimens Submitted for Serologic Evidence of Toxoplasmosis.*

| CASE NO. | AGE | X-RAY EVIDENCE OF CALCIFICATION | CHORIORETINITIS | SERUM TITER MOTHER | SERUM TITER PATIENT | ISLAND HOME |
|---|---|---|---|---|---|---|
| 5687-B§ | 4 | — | — | — | — | Honolulu |
| 4321§ | 4 | | — | 64 | — | Honolulu |
| 964 | 2 | — | — | — | — | Honolulu |
| 4296§ | 3 | | — | — | — | Honolulu |
| 5639 | 7 | — | — | — | — | Honolulu |
| 5637§ | 1⅔ | | — | — | — | Honolulu |
| 4634‡§ | 7 | + | + | 64 | 64 | Honolulu |
| 1675 | 5 | — | + | 256 | 256 | Honolulu |
| 5687-C | 30 | — | — | ¶ | — | Honolulu |
| 4811 | 1¾ | | — | — | — | Honolulu |
| 4698§ | 1¼ | | — | — | — | Schofield, Oahu |
| 2877‡ | 6 | — | — | — | — | Kaneohe, Oahu |
| 5640 | 10 | | + | 256 | 1024 | Waialua, Oahu |
| 5632 | 7 | — | + | 1024 | 16 | Hawaii |
| 757 | 21 | — | + | 64 | 16 | Hawaii |
| 5633 | 28 | | + | ¶ | 64 | Hawaii |
| 5634 | 17 | | + | 256 | 256 | Hawaii |
| 5635 | 17 | — | + | 64 | 256 | Hawaii |
| 5641 | 16 | — | + | 64 | 1024 | Hawaii |
| 5642† | 13 | — | + | 64 | 256 | Hawaii |
| 5643† | 20 | — | + | 64 | 16 | Hawaii |
| 1328 | 18 | — | + | 64 | 16 | Hawaii |
| 5687-A | 18 | + | + | — | — | Kauai |
| 5687-D | 48 | + | + | ¶ | 64 | Kauai |
| 5014 | 8 | — | — | — | — | Maui |
| 5017 | 7 | | + | — | 256 | Maui |
| 5687-G* | 13 | | — | * | — | Maui |
| 3742* | 6 | | — | * | — | Maui |
| 4912* | 5 | | — | * | — | Maui |

* Siblings—the mother's serum titer was reported less than 1:64
† Siblings—mother's titer 1:64
‡ Evidence of micro or hydrocephalus reported
§ Evidence of psychomotor retardation reported
¶ Serum of mother not available

Note: All but one of the 14 patients with positive dye test serum titers, and 7 of their mothers, were born in Hawaii.

In Table 1 are shown the data as to age, physical and serologic findings for 29 cases considered worthy of study. The specimens fall into two distinct groups—(1) 14 cases among which there was no evidence of chorioretinitis and (2) 15 cases among which chorioretinitis was reported as being definitely present in 14 cases and suspected in the remaining case, in which the physical state of the eye made observation of the retina almost impossible.

All of the 14 patients in whom evidence of chorioretinitis was not detected were also found to be negative as respects "dye test" titers of their sera for toxoplasmosis. One of the mothers in this group showed a titer of 1:64 and another was reported as less than 1:64 (positive in undiluted serum but negative in 1:64 dilutions) but

*Studies in toxoplasmosis conducted in this laboratory are supported by a grant-in-aid from the National Institutes of Health.

all of the remaining mothers were entirely negative.

In marked contrast to the foregoing, as may be seen from Table 2, moderate to high "dye test" titers against the toxoplasma were observed in sera from almost all of the cases with chorioretinitis (as well as practically all the sera from the mothers that were available.) Thus among the 15 cases of chorioretinitis, only one was serologically negative; as the mother on this case (an 18 year old individual) was also negative for the "dye test," it is not probable that the chorioretinitis in this instance was due to toxoplasma infection; four (26.6 per cent) showed titers of 1:4 to 1:16; three (20 per cent) had titers of 1:32 to 1:128; and in the remaining seven cases (46.7 per cent) the complement fixation titers were in the range 1:256 to 1:1024.

TABLE 2.—*"Dye Test" Titers of Sera from Patients with Chorioretinitis and Their Mothers.*

| TITER OF PATIENT'S SERUM | TITER OF MOTHER'S SERUM: NEG. | 1:4 TO 1:16 | 1:32 TO 1:128 | 1:256 TO 1:1024 | ?* | TOTAL PATIENTS |
|---|---|---|---|---|---|---|
| Neg. | 1 | | | | | 1 |
| 1:4 to 1:16 | | | 3 | 1 | | 4 |
| 1:32 to 1:128 | | | 1 | | 2 | 3 |
| 1:256 to 1:1024 | 1 | | 3 | 3 | | 7 |
| Total Mothers | 2 | — | 7† | 4 | 2 | 15 |

* Sera of two mothers not available
† Includes a mother of two patients

High titers were also reported on sera obtained from the mothers of these chorioretinitis cases. Thus, only 2 (16.7 per cent) of the 12 mothers (including the mother of the chorioretinitis child with a negative "dye test" previously referred to) from whom sera were available for examination, were negative; (sera were not obtainable from two mothers); 6 (50 per cent) had titers of 1:32 to 1:128 and in 4 (33.3 per cent) of the mothers the titers were high, being in the range 1:256 to 1:1024. One mother, whose serum showed a titer of 1:64, contributed two children with chorioretinitis and positive "dye test" titers for toxoplasmosis to this study—one, 20 years old, with a titer of 1:16 and another, 13 years of age, showing a titer of 1:256. In view of the report by Frenkel and Friedlander[9] that there have been no records of mothers giving birth to more than one toxoplasmatic child, this instance of possible multiple infection is worthy of note. The possibility, or probability, that one of these two cases may have been post-natal cannot, of course, be ruled out on the basis of presently available information.

The correlation between physical evidence of chorioretinitis and "dye test" titers for toxoplasma antibodies in sera of patients and their mothers, in contrast to the absence of any serologic evidence of toxoplasmosis in patients suffering from other ophthalmologic or central nervous system derangements, is striking and appears to be significant.

Considering that intensity of serologic response to infection, as indicated by serologic reactions (of which the "dye test" titer is a type), is a function of the stage of the disease and the period which has elapsed between the time of infection and collection of the serum specimen for examination, it is probable that the incidence of high titers for toxoplasmosis-positive serologic findings, reported herein, is conservative.

In a private communication, Feldman states that, even in the absence of calcification or psychomotor retardation, "presence of chorioretinitis in children young enough so that high titers of antibodies are present in both themselves and their mothers can best be interpreted as having resulted from a congenital infection with toxoplasma." Sabin[1] states "When healed chorioretinopathy is first discovered in school age children, the possibility of it being a 'healed' congenital toxoplasmic lesion can be entertained when the serum of *both* the mother and the child contain toxoplasmic antibodies, even of low titer, because the incidence of such antibodies in normal children under 15 years of age is probably less than 10 per cent."

The age distribution and toxoplasma "dye test" titers for the 15 patients with chorioretinitis are shown in Table 3. Considering the high titers (1:256 to 1:1024) observed among 4 of 6 children under 16 years of age; that, with one exception, the mothers of these children also showed high titers; and that for all of the cases a striking correlation was observed between incidence of chorioretinitis and toxoplasma antibody titers in both the patients and their mothers, the findings indicate (1) the possibility that toxoplasmosis exists in the Territory and, particularly, (2) that it would be desirable to include, in studies on new suspected cases, repeated serologic examinations over a considerable period of time with a view to verifying the possible endemicity of toxo-

[9] Frenkel, J. K., and Friedlander, S.: Toxoplasmosis . . . Pathology of Neonatal Disease, Pathogenesis, Diagnosis, and Treatment, Pub. Health Service Publication #141, 1951.

plasmosis, in Hawaii, by correlating the clinical, x-ray and other data with the serologic findings.

It is possible that many previously obscure syndromes may be related to fetal damage by toxoplasmosis. Areas which invite studious exploration might be any or all of the congenital abnormalities involving lesions of the central nervous system, including the eye. These would include cerebral palsy, hydrocephaly, microcephaly, and various phenomena of psychomotor retardation.

TABLE 3.—*Age Distribution and "Dye Test" Titers for Toxoplasmosis of Patients with Chorioretinitis.**

| AGE (IN YEARS) | SERUM TITER: NEG. | 1:4 TO 1:16 | 1:32 TO 1:128 | 1:256 TO 1:1024 | TOTAL |
|---|---|---|---|---|---|
| 0— 2 | | | | | |
| 2— 5 | | | | 1 | 1 |
| 6—10 | | 1 | 1 | 2 | 4 |
| 11—15 | | | | 1 | 1 |
| 16—20 | 1 | 2 | | 3 | 6 |
| 21—25 | | 1 | | | 1 |
| 25+ | | | 2 | | 2 |
| Total | 1 | 4 | 3 | 7 | 15 |

* All of the sera from 14 suspected cases *without chorioretinitis* were negative.

The subject of toxoplasmosis takes on more than ordinary academic interest in view of reports of suppressive effects of the sulfa drugs and particularly the recent work of Joy Barnes Cross[10] of the Department of Preventive Medicine and Public Health, Medical Branch, University of Texas, whose findings, with a limited number of white mice infected with a rapidly fatal toxoplasmosis, indicate that Diasone and Promin have not only suppressed the symptoms but effectively eliminated the carrier state.

## Summary and Conclusions

1. For many years, ophthalmologists have been impressed by an apparently high incidence of chorioretinopathy in children in the Territory of Hawaii.

2. Through the collaboration of Dr. Harry Feldman of the Department of Medicine, State University of New York, Medical Center at Syracuse, it was possible to determine the toxoplasma antibody titers for sera of a series of patients having ophthalmologic or central nervous system defects of obscure origin where congenital toxoplasmosis might appropriately be included as a possible differential diagnosis.

3. The correlation between physical evidence of chorioretinitis and "dye test" titers for toxoplasma antibodies in sera of patients and their mothers, in contrast to the absence of any serologic evidence of toxoplasmosis in patients suffering from other ophthalmologic or central nervous system derangements, is striking and appears to be significant.

4. Considering the high titers found in 4 of 6 children under fifteen (and in all but one of their mothers), and the striking correlation between these high titers and the occurrence of chorioretinitis, we conclude that:

a. The presence of toxoplasmosis in the Territory of Hawaii, heretofore not reported, seems to be established.

b. There is a need for further study and investigation to determine the possible correlation of serologic evidence of toxoplasmosis with not only chorioretinitis but other central nervous system disorders found in the Territory.

c. It would be desirable to include, in studies on new suspected cases, repeated serologic examinations over a considerable period of time with a view to verifying the endemicity of toxoplasmosis in the Territory of Hawaii, by correlating clinical, x-ray and other data with the serologic findings.

## Acknowledgments

Acknowledgment is made to the physicians of the Territory for their interest and cooperation, especially to Dr. Howard E. Crawford of Hilo, Hawaii, who inspired this study; to Dr. Samuel M. Wishik, Professor, Maternal and Child Health, with the University of Pittsburgh, who launched preliminary investigations in the Territory in 1943; to Dr. C. L. Wilbar Jr., President of the Territorial Board of Health, for his persistent interest and encouragement; to Mrs. Ellen Luke Wakayama for her faithful service in compiling data; and particularly to Dr. Albert B. Sabin of the Children's Hospital Research Foundation, Cincinnati, Ohio, for his stimulating interest, and Dr. Harry A. Feldman for his gracious cooperation in performing the serologic tests.

[10] Cross, J. B.: Diasone and Promin as Therapeutic Agents in Experimental Toxoplasmosis, Proc. Soc. Exp. Biol. and Med. 76:548 (Mar.) 1951.

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# Congenital Toxoplasmosis

## Report of a Fatal Case in Hawaii

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HONOLULU

TOXOPLASMOSIS is an infection caused by a small lunate-shaped organism, Toxoplasma gondii, which is generally believed to be a protozoon. According to Frenkel[1] the organism was first described by Nicolle and Manceaux from the Institut Pasteur in Tunis in 1908. The name is derived from the Greek word toxon, meaning bow or arc, and the specific name gondii from the name of the type host, the gondi, a small North African rodent which was used as a laboratory animal at the Pasteur Institute, and from which the organism was first isolated. It has since been found in many other animal hosts including rabbits and guinea pigs.

The first well authenticated human case was described by Janku in Czechoslovakia in 1923 and in 1937 Wolf and Cowen reported the first instance of human infection in the United States (Frenkel[1]). In 1942 Paige, Cowen and Wolf[2] described 4 additional cases in infants and children. An extensive literature has since accumulated on the subject; for a selected bibliography and a thorough discussion of the disease, the reader is referred to the report by Frenkel and Friedlander.[3] A recent publication by Sabin, Eichenwald, Feldman and Jacobs[4] outlines the present status of the disease very well and contains a particularly good discussion on the serologic tests and their interpretation. The monograph by Hogan[5] should be consulted by those who are interested in the ocular manifestations of the disease.

### Clinical Aspects

The mode of transmission of toxoplasmosis to adults is unknown, and most persons with the infection have no symptoms of any sort. During pregnancy, however, an infected mother, even though showing no manifestations of the disease herself, may infect her offspring through the placenta with resulting serious or fatal disease in the baby.

During the neonatal period the following findings should suggest the possibility of congenital toxoplasmosis: (1) encephalitis; (2) rash; (3) jaundice; (4) hepatosplenomegaly; (5) hydrocephalus or microcephaly; and (6) chorioretinitis. Later during infancy and childhood, convulsions, hydrocephalus or microcephaly, psychomotor retardation, cerebral calcification and chorioretinopathy are highly suggestive of the disease. The tetrad of (1) chorioretinitis; (2) cerebral calcification; (3) hydrocephalus or microcephaly; and (4) psychomotor disturbances is associated with positive serologic findings in 80 to 90 per cent of cases. A diagnosis cannot, however, be made on the basis of clinical findings alone.



DR. TILDEN

The extent of the clinical manifestations at birth and in the neonatal period depends upon the time of infection during pregnancy. If the infection is transmitted from the mother to the child early in pregnancy, the disease may be fully developed in the newborn child, and the child may be born dead. If late, the infant may show manifestations of early acute infection such as convulsions, rash, jaundice and hepatosplenomegaly.

Frenkel and Friedlander[3] have divided the disease into acute, subacute and chronic stages. In the early acute stage, many tissues and organs may be involved, but with the rapid development of antibodies, the infection becomes localized in the central nervous system and the eye, where the greatest damage is produced. The low titer of antibodies present in cerebrospinal fluid as compared to the blood serum is advanced as a possible explanation for localization of the organisms in the brain and the eye.

### Laboratory Aids in Diagnosis

In the acute and subacute stages of the disease, the organisms can sometimes be demonstrated in

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[1] Frenkel, J. K.: Pathogenesis, Diagnosis and Treatment of Human Toxoplasmosis, J.A.M.A. 140:369 (May 28) 1949.

[2] Paige, B. H.; Cowen, D.; and Wolf, A.: Toxoplasmic Encephalomyelitis, Am. J. Dis. Child. 63:474 (Mar.) 1942.

[3] Frenkel, J. K. and Friedlander, S.: Toxoplasmosis: Pathology of Neonatal Disease, Pathogenesis, Diagnosis, and Treatment, Public Health Service Publication, No. 141, U. S. Government Printing Office, Washington 25, D. C., 1951.

[4] Sabin, A. B.; Eichenwald, H.; Feldman, H. A.; and Jacobs, L.: Present Status of Clinical Manifestations of Toxoplasmosis in Man, J.A.M.A. 150:1063 (Nov. 15) 1952.

[5] Hogan, M. J.: Ocular Toxoplasmosis, Columbia University Press, New York, 1951.

stained smears of ventricular fluid, or by inoculating the fluid into mice and guinea pigs. The ventricular fluid from cases of congenital toxoplasmosis has an extremely high protein content which may be over 1,000 mg. per cent. The serologic tests, however, offer the most feasible and practical means of diagnosis.

The dye test or cytoplasm-modifying test, first described by Sabin and Feldman,[6] is the most useful and can be closely duplicated in different laboratories familiar with the procedure. It was found that the cytoplasm of toxoplasma, acted on by a specific antibody and a complement-like accessory factor present in normal human serum, loses its affinity for methylene blue in a solution buffered at *p*H 11. The dye test titer is the highest dilution of the serum being tested which, in the presence of a constant adequate amount of accessory factor, is capable of depriving the cytoplasm of 50 per cent of extracellular toxoplasma of their affinity for methylene blue at *p*H 11. Living toxoplasma are necessary, which is the main disadvantage of the test. The great majority of normal people have a dye test titer of 1:64, or less. In active toxoplasma infection dye test antibody develops within ten to twenty days in titers of 1:256 to 1:4000, and may persist for as long as five years.

In the complement-fixation test, a soluble antigen is used which consists of an isotonic saline solution extract of toxoplasma-infected chorioallantoic membrane of chick embryo which is purified by centrifugation at 13,000 rpm for one hour. A similar extract of non-infected chorioallantoic membrane is used as a control. A positive test in a titer as low as 1:2 is apt to be specific if the controls are all right, since such serums invariably contain significant amounts of cytoplasm-modifying antibody. Complement-fixing antibodies appear much later and disappear earlier than the cytoplasm-modifying antibody.

The dermal sensitivity test, using toxoplasmin injected intradermally in 0.1 ml. amounts, may give a positive tuberculin type reaction in persons who have the disease. But according to Sabin et al.,[4] a considerable proportion of persons with toxoplasma antibody fail to give a positive skin test, and children with proven congenital toxoplasmosis often give negative reactions. Thus a negative test does not indicate absence of antibody or infection, and a positive test does not differentiate between persons having dye test titers of dubious significance such as 1:4 and those with highly significant titers of 1:256, or more.

[6] Sabin, A. B. and Feldman, H. A.: Dyes as Microchemical Indicators of a New Immunity Phenomenon Affecting a Protozoon Parasite (Toxoplasma), Science, 108:660 (Dec. 10) 1948.

The Communicable Disease Center of the United States Public Health Service has established a toxoplasma diagnostic laboratory to perform these serologic tests.* At the present time specimens for the diagnosis of congenital toxoplasmosis are the only ones which will be accepted. Under aseptic conditions 5 to 10 ml. of blood are taken from both mother and child using no anticoagulants or preservatives. The specimens are sent to the laboratory of the state health department which will then transmit them to the Communicable Disease Center. Clinical information must be supplied with the specimens. In suspected acute congenital toxoplasmosis, a physician may submit such specimens directly if he gets permission from local health department authorities.

## Case Report†

Mrs. J. C., age 21, Filipina, gravida II, para I, was first seen at the Ewa Plantation Hospital on May 31, 1952. Her last menstrual period was in November, 1951. Physical examination was negative except for the findings of a normal six months' pregnancy. The fetal heart tones were audible in the right lower quadrant and the blood pressure was 168/90. Her weight was 151 pounds. Laboratory examination showed a negative urine, a hemoglobin of 13.1 grams, a red blood cell count of 4.1 million and a negative Kahn. The patient was Type O, $Rh_0$ positive.

The patient was again seen on June 28, 1952, at which time a routine examination was negative. Her blood pressure on this visit was 100/76, the urine was negative, and the fetal heart tones were present over the left lower quadrant.

On August 2, 1952, the patient was admitted to the hospital in active labor. There were no signs or symptoms of toxemia. Her temperature on admission was 99° F. A full term, living female infant was delivered spontaneously at 10:58 P.M. on August 2, 1952. The air passages were aspirated and the infant cried spontaneously. The birth weight was 5 pounds, 3 ounces, and physical examination after delivery revealed no abnormal findings. The following day, August 3, 1952, petechiae appeared over the face and neck. Aside from this, the condition of the infant appeared to be satisfactory and she nursed well. At 6:00 P.M. on the same day, death occurred rather suddenly approximately eighteen hours following delivery.

An autopsy was performed on the baby by Dr. Francis K. Won on August 4, 1952. The spleen was enlarged but the other viscera showed no gross abnormality. The cranial cavity was filled with thick, yellowish fluid, and the brain had undergone extensive liquefaction and degeneration, only the brain stem showing recognizable gross contours. The remnants of brain tissue were placed in 10 per cent formalin and submitted for pathologic examination.

* Address: Communicable Disease Center (Toxoplasma Laboratory), P. O. Box 185, Chamblee, Georgia.

† This case is reported through the courtesy of Dr. Garton E. Wall and Dr. Francis K. Won, Ewa Plantation Hospital, Ewa, Oahu, Hawaii.

Grossly the material consisted of many irregular bits of soft, degenerated brain tissue, and several larger portions of membrane representing meninges to which brain tissue was attached. There were many small, irregular yellowish-white placques and nodules scattered over the meninges and present to a lesser extent within the brain tissue itself (Fig. 1). These were quite small, most of them measuring only a few millimeters in diameter. Structural orientation was, of course, impossible, due to the degenerated nature of the material.



Fig. 1. Gross appearance of the degenerated brain tissue. There were many small yellow placques and nodules scattered over the meninges (arrows).

Histologic examination showed extensive and widespread chronic meningoencephalitis characterized by destruction of brain tissue, and by monocytic, lymphocytic and plasma cell infiltration. The latter were particularly numerous and some were binucleated. Scattered throughout, but concentrated toward the surface in the region of the meninges, were many deposits of calcium which varied in size, but which were generally quite small. These calcium granules tended to form a calcific zone on the surface of the brain, and were particularly well shown by Kossa stains (Fig. 2). The meningeal vessels were dilated and engorged with blood. There were a few poorly circumscribed nodules (the microglial nodules of Frenkel or miliary granulomas of Cowen) made up of a variety of cells, most of which appeared to be of plasma cell or histiocytic nature.

The possibility of toxoplasmosis was considered from the start because of the histologic features mentioned above, but no organisms could be found. Finally, after study of many slides, a few pseudocysts containing the

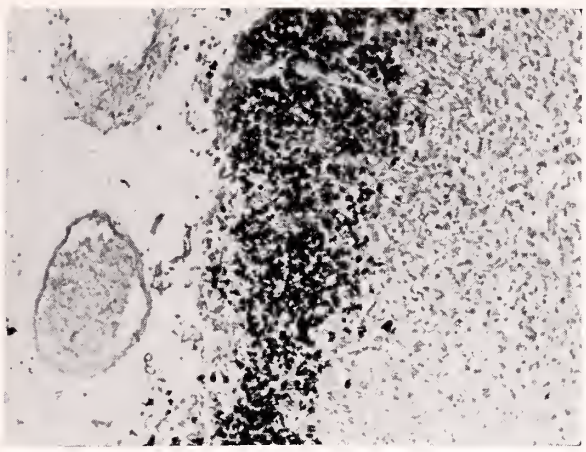


Fig. 2. Kossa stain to show calcified meningeal zone. The calcium granules stain black. Dilated meningeal vessels are present to the left. X 60.

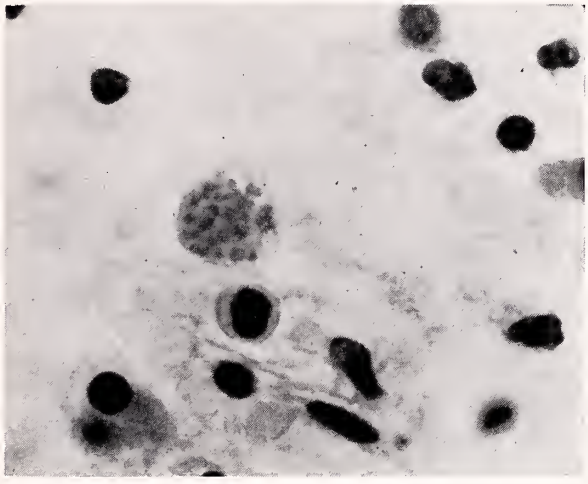


Fig. 3. Sharply outlined pseudocyst containing toxoplasma. Hematoxylin and eosin. X 675.

organisms were discovered (Fig. 3). These were rather small—15 to 25 microns—had a sharp limiting membrane, and contained 30 to 40 organisms. They were located within the degenerated brain substance (none were found in the calcified meningeal zone) and as already mentioned were few in number and hard to find, not more than two occurring in the plane of a single section, and many sections containing none at all. No proliferative forms of the organism could be found either intra- or extra-cellularly. Unsuccessful attempts were made to stain the pseudocysts with the PAS (periodic acid-Schiff) technique, and none could be found in sections stained by Gram-Weigert, Giemsa and polychrome methylene blue methods.

At the suggestion of Dr. Grant Stemmermann of Hilo, Hawaii, (who had observed no pseudocysts in the brain tissue sent to him) material was sent to Dr. David Cowen, of New York, who wrote as follows: "I . . . believe the pathological process is quite characteristic of congenital toxoplasmosis with an intense chronic inflammation, calcification, miliary granuloma formation and scattered pseudocysts. Since the child was only 18 hours

old at the time of death, the infection must have been present for a considerable period before birth. I do not think that the negative skin test in any way invalidates the diagnosis."

On October 7, 1952, two months following delivery, the mother was examined by Dr. Fred I. Gilbert, Jr., at the Straub Clinic. She had no complaints and stated that she had been entirely well throughout her pregnancy. She was born in Hawaii and had lived here all of her life. Her husband and first child, a boy aged 2½, have always been in good health. A careful physical examination was entirely negative. An eye examination by Dr. Thomas W. Cowan was likewise negative. Skull and chest x-rays were reported negative by Dr. Peter J. Washko. Laboratory examination showed 8,000 white cells per cu. mm., negative serologic tests for syphilis, and a slightly elevated sedimentation rate. An electrocardiogram (Lead I) was negative.

Blood was obtained under sterile precautions at this time (10-7-52) and the serum was sent to Dr. Michael J. Hogan at the University of California College of Medicine for dye and complement-fixation tests. A skin test was then done by injecting 0.1 ml. of toxoplasmin (Lilly) intradermally; this had produced no reaction at the end of seventy-two hours.

A positive dye test titer through 1:2048 was obtained in Dr. Hogan's laboratory on November 17, 1952, and the test was repeated on the same serum on December 3, 1952, at which time the titer had dropped to 1:512. (This was thought to be the result of heavy bacterial contamination which made the end point difficult to determine.) A complement fixation test was 4 plus in a 1:5 dilution which was regarded as significant. Dr. Hogan also stated that he had found a fair number of both intra- and extra-cellular organisms in the tissue which was subsequently sent to him.

1020 Kapiolani St.

## Comment

The baby herein reported died of severe congenital toxoplasmosis, the first case of its kind to be reported in Hawaii. The disease, at least in its fatal form, is rather rare. Frenkel[1] in 1949 stated that about 35 cases of human toxoplasmosis had been reported diagnosed either by autopsy or animal inoculation. Non-fatal forms of the disease, however, are probably much more common than anyone has suspected. For example, Eichenwald, at the New York Hospital, diagnosed 100 cases of congenital toxoplasmosis between 1948 and 1952, and Feldman diagnosed 75 cases at the State University of Syracuse, New York, from 1949 to 1952, by serologic methods.[4] A large proportion of the normal population (about 50 per cent in the older age group) in urban and rural areas has cytoplasm-modifying antibody although, as already mentioned, the titer is usually less than 1:64.

The establishment of the diagnosis of acute congenital toxoplasmosis is of importance for two reasons: first, a good prognosis can be given for future pregnancies since there has been no reported instance in which a mother has given birth to more than one infected baby; and second, treatment by sulfonamides may favorably influence the course of the disease. The new anti-malarial drug, pyrimethamine (Daraprim), combined with sulfadiazine, has been successfully used in experimental toxoplasmosis.[7]

[7] Potent Anti-Malaria Drug, Sci. News Letter, 62:323 (Nov. 22) 1952.

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# Observations on a Study of 100 Cases of Acute Upper Respiratory Disease

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IN Hawaii the incidence of acute upper respiratory disease generally follows a wave-like pattern without any apparent seasonal or geographic significance. It is not uncommon to hear of mild "epidemics" of influenzal, viral, or streptococcal infections. The question arises as to whether sufficient etiological studies have been done in the diagnosis of these infections. The truth is that some are confirmed etiologically but the majority are diagnosed clinically on the basis of symptoms and response to treatment.



DR. KUHLMAN

The importance of etiologic studies can best be borne out if one considers the possible relationship of these infections to the prevalence of rheumatic heart disease in the islands. The reports in the literature by Berk and Hartwell[1] in 1949 and by Connor and Yoshina[2] in 1951 indicated a frequency of rheumatic fever and rheumatic heart disease in Hawaii not hitherto supposed. Leedham and Smith[3] in 1952 reported an incidence of rheumatic valvular heart disease in Hawaii comparable to that in many areas in the mainland United States. They also reported a correspondingly low incidence of prior knowledge of rheumatic fever. In the light of what these authors have reported and what is generally known about rheumatic fever in the Territory, it is logical to assume the likelihood of rheumatic fever's appearing disguised as an innocuous upper respiratory infection.

A study of 100 cases of an acute upper respiratory infection was undertaken with the thought of possibly determining the presence of rheumatic fever. These cases were selected from a large number of respiratory infections occurring in September of 1951. Selection was based on the symptom complex present at that time.

### Symptoms

The symptoms most commonly exhibited were: a complaint of an aching in the body, especially in the back and extremities; chilliness; malaise; fever; mild headaches; a frequent complaint was that of sore throat from mild (described as a tickling sensation) to moderate; dryness of the nasal passages. The best description of these symptoms was that of an influenzal pattern.

### Physical Findings

Fever usually ranged from 100 to 104° F. Most constant was an erythematous granular lymphoid hyperplasia of the posterior nasopharynx without exudate. The nasal passages were for the most part clear, with little or no discharge. Cervical adenopathy was infrequent.

### Method of Study

Throat cultures and blood cultures were taken whenever possible, before treatment. Bacteriological identification of the predominant organisms was done by Mr. G. Fernandes of the Board of Health Laboratory on Kauai. Additional specimens were sent to Honolulu for confirmation of the identification. White blood cell counts and differential counts were done whenever possible up to four weeks following the onset of the disease. EKGs were attempted but were abandoned due to the fact that they could not as a rule be taken until a considerable time after the onset of the disease. In addition to this, the only no-cost facilities for taking EKGs were provided by a physician in a town some fourteen miles distant, which resulted in obvious transportation difficulties for the patients.

All patients were checked thoroughly for the presence of organic valvular heart disease. Follow-up examinations were done at three-month and six-month intervals on all those patients with organic heart murmurs.

[1] Berk, M. E., and Hartwell, A. S.: Five Years of Heart Disease in Hawaii, HAWAII MED. J. 8:177 (Jan.-Feb.) 1949.

[2] Connor, A., and Yoshina, T.: Rheumatic Fever in Hawaii, HAWAII MED. J. 10:181 (Jan.-Feb.) 1951.

[3] Leedham, C. L., and Smith, L. A.: Rheumatic Heart Disease in Inductees in Hawaii, HAWAII MED. J. 11:211 (Mar.-Apr.) 1952.

## Results of Study

*Laboratory:*

*Throat Cultures.* Thirty-one of the cultures of the throat taken were planted on Loeffler's medium. The predominant organism was identified as being a gram positive coccus occurring in chains. Transfer of the predominant Loeffler colonies to blood agar resulted in four of the specimens revealing hemolysis; the remaining cultures of the series were planted in a thioglycollate medium. Predominant organisms were again transferred to blood agar. As a result of this procedure, forty-five of the first hundred throat cultures had the predominant organism identified as alpha hemolytic streptococcus. Twenty-two additional cultures on patients not followed otherwise in this study were sent to Honolulu for more exact identification. Fifteen of these contained predominantly alpha hemolytic streptococcus organisms. We might assume then that the first thirty-one cultures contained more than four cultures with alpha hemolytic streptococci.

*Blood Cultures.* One of the blood cultures revealed a growth of staphylococcus citreus, obviously a contaminant. There was no growth in any of the other specimens.

*White Blood Cell Counts.* Fifty-two of the 100 patients had white blood cell counts done on the first day, before treatment. The average count for this period was 10,009 with an average of 83 per cent polymorphonuclear cells.

*Sedimentation Rates.* The results are shown in table form below. An index of 10 mm. in sixty minutes was considered abnormal. All readings of 10 mm. and above were then averaged so as to lend a greater accuracy to the results.

TABLE 1.—*Sedimentation Rates by Cutler Technique.*

| DAYS | NO. OF SED. RATES | NO. OF ABNORMAL SED. RATES | | | ABNORMAL AVERAGE SEDIMENTATION INDEX/60 MIN. IN MM. | |
|---|---|---|---|---|---|---|
| | | *Adults* | *Children* | *Total* | *Adults* | *Children* |
| 1 | 74 | 15 | 41 | 56 | 23 | 23 |
| 2 | 48 | 12 | 26 | 38 | 23 | 21 |
| 3 | 20 | 3 | 13 | 16 | 20 | 17 |
| 4 | 17 | 4 | 12 | 16 | 22 | 20 |
| 5 | 12 | 4 | 8 | 12 | 35 | 20 |
| 6 | 5 | 2 | 2 | 4 | 31 | 23 |
| 7 | 7 | 0 | 6 | 6 | 0 | 19 |
| 8 | 12 | 1 | 8 | 9 | 22 | 18 |
| 9 | 3 | 0 | 2 | 2 | 0 | 17 |
| 10 | 17 | 5 | 9 | 14 | 21 | 14 |
| 11 | 4 | 1 | 3 | 4 | 15 | 16 |
| 12 | 10 | 4 | 6 | 10 | 36 | 13 |
| 13 | 4 | 0 | 3 | 3 | 0 | 17 |
| 14 | 17 | 2 | 15 | 17 | 12 | 17 |
| 21 | 15 | 2 | 13 | 15 | 12 | 14 |
| 28 | 13 | 4 | 8 | 12 | 15 | 18 |

*Clinical:*

*Temperatures.* The average temperatures for the first seven consecutive days of the one hundred cases were 100.2°, 99.1°, 99.3°, 99.2°, 99.2°, 98.8°, and 98.8°. Two patients showed a recurrent temperature elevation up to 104° and 100.2°, respectively, in the second week following the onset of their disease. These were of no particular significance in relation to the subsequent clinical course of these two cases.

*Heart Findings.* Twenty-six patients exhibited organic mitral systolic murmurs. Four of these patients were known to have had the same murmurs previously. None of the remaining patients gave any history of previous murmurs or of rheumatic fever. All of these murmurs were detected on the initial visit.

*Follow-up on Heart Findings.* Examinations done at three- and six-month intervals revealed that 16 of the original 22 cases had persistent organic mitral systolic murmurs. Fifteen of these were children ranging in age from four to nine years.

Six of the children had showed no evidence of murmurs in pre-school examinations done only two months prior to the onset of their disease. None of the children had any prior history of rheumatic fever. The one adult concerned was a nineteen year old boy who had showed no evidence of a heart murmur in an employment physical taken one year previously. This person was later rejected in an inductee examination on the basis of the cardiac findings discovered in this study. Eight of these patients had positive identification of alpha hemolytic streptococcus on throat culture.

## Treatment and Results

All of the patients in this series were given 600,000 units of procaine penicillin intramuscularly for three days, or longer if the response to treatment warranted it. The great majority of the patients showed a remission of fever and abatement of symptoms within the first twenty-four hours after the onset of treatment. At the end of the forty-eight hour period in treatment a clinical cure had been effected in most of the cases.

## Summary

A study of 100 cases of an apparent upper respiratory infection is presented. The condition was characterized by a granular erythematous pharyngitis, influenzal symptoms, a febrile state and an elevated white blood cell count. Eighty-seven per cent of the sedimentation rates taken were abnormal. The causative organism of this disease was identified as being alpha hemolytic streptococcus.

Sixteen per cent of the cases studied appeared to have sustained organic mitral valvular damage, evident up to a six-month period following the onset of the disease. Ninety-four per cent of these murmurs occurred in children under ten years of age.

## Comment

The inaccuracies of this study under the circumstances in which it was made are considerable. Complete laboratory studies were impossible due to the lack of facilities and technical help. Nevertheless, it is felt that certain valid observations can be made.

These cases represented an upper respiratory infection identified as a streptococcic pharyngitis. Further identification of the streptococcic organism into sub-type would have been of value in appraising the etiological significance of the infection in relation to the development of mitral valvular disease.

The absence of any positive blood cultures or of an eosinophilia suggests that the mechanism of production of the cardiac lesion was on the basis of a toxic reaction. The measurement of antistreptolysin serum titers might have been of significance in this instance.

The effect of the treatment on the course of the disease is one of conjecture. While it is certain that the use of penicillin resulted in the subsidence of symptoms and apparent clinical cure within forty-eight hours, it did not prevent the development of cardiac pathology. Penicillin might have modified the cardiac effect of the disease, but this cannot be established in the absence of any control studies.

No conclusion can be drawn concerning the positive identification of rheumatic fever with the upper respiratory disease demonstrated in this study.

It is hoped that the suggestive evidence presented here will provoke a truly scientific inquiry into the etiological relationship of acute upper respiratory disease to rheumatic fever.

115 Cl. Co., 40 Inf. Div.
APO #6, c/o P. M.
San Francisco, California

The final draft of this paper was typed within 3 miles of the front line in Korea in below freezing temperature. Dr. Kuhlman was acting as battalion surgeon for a field artillery unit at that time.

*Even a small donation to the American Medical Education Foundation is a boost for Hawaii!*

# Neonatal Emergencies

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DISEASES of the newborn are in many respects peculiar and in general the causes differ from those operating in later life.



DR. WILE

Infants may die soon after birth of any of the conditions that cause death before or during labor. Many of the diseases result from the failure of the infant to make the anatomic and physiologic adjustments necessary after birth. Some are the results of accident or trauma incident to labor. A large group is represented by diseases or infections to which the newborn is peculiarly susceptible or particularly exposed. Some congenital malformations are seen only in the newborn period, either because their serious nature is incompatible with prolonged life or because they tend to be outgrown. Prematurity is a major cause of death. And finally, any illness occurring in the neonatal period is likely to be severe since the infant at this time is a much more delicate organism than in any other phase of its existence.

Emergencies which one may encounter in this large group of pathologic conditions are many and varied. Some are of such a nature that little can be done therapeutically. In others, however, the survival of the infant may depend upon prompt diagnosis and the immediate institution of appropriate therapy.

It is obviously impossible to discuss in detail all of the hazardous conditions which may develop during the newborn period. I shall confine myself, therefore, to briefly mentioning those more commonly encountered and devote most of my time to those conditions which, at present, seem to offer the greatest promise of success with adequate treatment.

### Oxygen Deficiency

Undoubtedly the most frequently encountered emergency in the neonatal period is that of oxygen deficiency.

At birth the newborn child must satisfy immediately its own oxygen requirements through a new and untried anatomic and physiologic system. The control of this system lies in the respiratory centers, backed up by the emergency carotid and aortic chemoreceptors.

These centers may have been damaged by anoxia, either in utero or during delivery; by actual traumatic injury during birth; by the direct effect of maternal analgesia or anesthesia; or by a combination of these various factors. In addition to the failure of the respiratory centers to function, extrauterine anoxia may be due to mechanical obstruction of the airways from aspirated fluid, blood, vernix or meconium; to pathologic changes in the lungs secondary to intrauterine anoxia, infection, or trauma; or to congenital malformations of the respiratory tract or circulatory system.

Asphyxia in the newborn is usually described as mild, moderate or severe. I would like to stress, however, that the condition of the asphyxiated newborn is never static. If mild asphyxia is present at birth, the baby either recovers rapidly or proceeds through the moderate and severe stages to death. This latter possibility must always be kept in mind when a mildly asphyxiated baby is being treated.

The immediate resuscitation of the newborn remains primarily the responsibility of the obstetrician. The techniques of resuscitation vary considerably. There are certain basic principles, however, on which we all agree. First, the patency of the airways must be maintained; second, oxygen must be delivered to the lungs; and, third, the baby must be kept warm. Gentleness in handling the infant cannot be too strongly emphasized. Direct laryngoscopy and bronchial drainage are seldom indicated and may be injurious. Mechanical respirators and the use of positive pressure in expanding the alveoli are unphysiological, futile, and dangerous. The so called respiratory stimulants, such as alpha-lobeline and Coramine, apparently act through the carotid body of the chemoreceptor system to stimulate the medullary center. Unfortunately, their usefulness is limited. As a rule, small doses cause little effect and large doses may be harmful. In the occasional instance, they may produce a few gasps, permitting sufficient oxygen to reach the respiratory center to initiate respiration. If such a result is not secured

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promptly, and with a moderate dose, little is to be gained by giving larger doses and considerable harm may be done.

It has been recently shown that inflation of the stomach, with oxygen to be absorbed by the gastric mucosa, is effective despite apnea or insufficient respiration. Such a procedure is simple, may be carried out by untrained assistants, and warrants further investigation.

Infants delivered by Caesarean section seem to have a disproportionately higher incidence of asphyxia and are particularly prone to develop respiratory difficulties. These babies frequently have an excessive amount of secretion in the airways and in the stomach, which may be vomited and aspirated. For some time now, in addition to the careful clearing of the air passages, we have been routinely aspirating at birth the stomachs of all infants born by section. Our impression is that the procedure is a valuable one.

Any infant who has been exposed to even a short period of anoxia should be kept in an atmosphere of 50-60 per cent oxygen with a humidity approximating 80 per cent for at least twelve to twenty-four hours. Suction equipment should be constantly at hand and used to remove all excessive secretion. It is most important that the infants be checked at frequent intervals by the nursery personnel. Antibiotics are given routinely to all infants subjected to tracheal catheterization or if there has been an early rupture of the amniotic sac. We are not too concerned about hydration during the first couple of days. Many anoxic babies develop some edema. The administration of subcutaneous fluids at this time may do more harm than good. Later, if the baby cannot be fed, they are necessary. Oral feedings are started only after the respiratory distress has been relieved.

Anoxia in premature infants is often due to the immature development of the lungs. In such cases, the persistence of the cuboidal epithelium which lines the alveoli forms a barrier to an adequate respiratory exchange.

In the past few years, we have become increasingly aware of the pathologic condition designated by Potter as "hyaline membrane with resorption atelectasis." At the Lying-in Hospital in Chicago, Potter finds this condition to be responsible for more deaths of live born infants than any other single cause. The clinical and pathological findings are characteristic, and when recognized, are rarely confused with those of any other disease. It is more frequent in premature than in full term infants. These infants usually breathe spontaneously at birth, and for the first hour or so seem normal. Later progressive cyanosis and dyspnea develop. Breathing becomes extremely labored and breath sounds gradually become less audible. Occasionally respiration improves and recovery takes place. More often death occurs, usually in a few hours. The pathologic picture is identical in all cases. The lungs are enlarged, dark red purple in color, and of uniform firm consistency. Histologic examination reveals a widespread resorption of air, with collapse of the alveoli and alveolar ducts. The inner surfaces of the alveolar ducts which remain open are covered by an irregular layer of hemogeneous acidophilic material which forms a mechanical barrier to normal respiratory exchange. The origin of this substance has not been definitely established. There is no specific treatment. The incidence of hyaline membrane seems to be reduced, however, by placing all infants with respiratory distress in an atmosphere of 50-60 per cent oxygen with 80-90 per cent humidity.

The possibility of pneumomediastinum or pneumothorax should always be considered in the differential diagnosis of dyspnea in newborn. I believe its incidence to be higher than we suspect.

Pneumomediastinum probably occurs as the result of alveolar rupture which produces an interstitial emphysema, and the subsequent passage of the air along the vascular sheaths to the mediastinum. From there the air may pass into the subcutaneous tissue, or to the pleural cavity, or to both. Occasionally, pneumothorax may develop without a preceding pneumomediastinum as the result of rupture of an alveolus just beneath the pleura. In most of these cases, a history of artificial resuscitation can be obtained. If respiration has been spontaneous, one may assume that the infant's attempts to overcome an obstruction in its bronchi or trachea raised the intra-alveolar pressure sufficiently to cause rupture of the walls.

Spontaneous pneumomediastinum is characterized by the sudden appearance of respiratory distress and varying degrees of cyanosis with or without such signs as distention of the veins of the neck, bulging of the precordium, distant heart tones, obliteration of cardiac dullness, a crackling sound synchronous with the heart beat, subcutaneous emphysema, or signs of pneumothorax. Less frequently the symptoms may develop slowly. The diagnosis is established by lateral and posteroanterior x-rays of the chest. Unless respiratory distress is immediately evident, the treatment should be conservative. These babies must be carefully watched, however, and any increasing dyspnea or cyanosis is an indication for immediate therapeutic aspiration.

### Intracranial Hemorrhage

Intracranial hemorrhage is second only to anoxia as a cause of morbidity and mortality during the neonatal period. Although intracranial hemorrhage may occur with anoxia, with prematurity and possibly with hypoprothrombinemia, in most instances it is due to birth trauma. It is important to realize that the normal stress experienced in uneventful birth leaves no obvious effects upon the mature infant apart from molding of the skull and edema of the scalp. Unnatural stress due to prolonged or difficult labor, particularly if associated with immaturity or anoxia, is liable to be followed by congestion of the blood vessels or rupture of the dural septa. The most common sites of intracranial hemorrhage are tears in the tentorium, rupture of the vein of Galen, or bleeding from one of the meningeal vessels. Hemorrhage into the subarachnoid space and small localized hemorrhages in the brain substance are almost invariably the result of anoxia and are not caused by mechanical injuries.

It is often difficult to differentiate the effects of trauma from those of anoxia during the early days of life and it is usually impossible to localize the area of hemorrhage.

The commonest symptoms of intracranial hemorrhage soon after birth are lethargy, a general failure to respond to normal stimuli, inadequate sucking reflex, irregular respirations with periods of apnea and cyanosis, and muscular twitchings or convulsions, either localized or generalized. The anterior fontanel may be tense or bulging. Spinal tap may be of aid in the diagnosis.

It cannot be too strongly emphasized that the infant suffering with intracranial injuries should be handled as little as possible. Our fault is often one of too much, rather than too little, therapy. Oxygen, heat, and quiet are the chief therapeutic points to be kept in mind during the critical first seventy-two hours of life. Vitamin K should be given for whatever value it may have. Oral administration of fluids should be withheld until the sucking and swallowing reflexes are well established. Spinal drainage has little therapeutic value.

### Heart Disease

The treatment of cardiac conditions in the neonatal period involves essentially the differential diagnosis of cyanosis in the newborn. An infant with a congenital cardiac anomaly may present a picture of persistent or intermittent cyanosis, poor feeding, vomiting, and lethargy. This picture is similar to that seen in respiratory disease, central nervous system damage, and acute septicemia. In congenital heart disease, however, there will usually be a heart murmur, x-ray evidence of cardiac enlargement, or an abnormal electrocardiogram. Occasionally, none of these signs is present, and in such cases the diagnosis must be made by the exclusion of other possibilities. In some instances of congenital heart disease, the cyanosis is markedly aggravated by crying. This is at times an aid in the differential diagnosis.

In infants with congenital heart disease, the sudden onset of congestive failure may present an acute emergency. The treatment is rapid digitalization. Digoxin or digitoxin, intravenously, is usually the drug of choice. Digoxin acts somewhat more rapidly, but is excreted faster. One-half the calculated dose should be given immediately and, depending on the infant's condition, the full second half should be given three or four hours later or given in divided doses at three to four hour intervals. In severe cases, where an immediate effect is desired, strophanthin should be used. This drug acts much more rapidly, but is not without danger.

Paroxysmal tachycardia may also present an acute emergency during the newborn period. The clinical signs are usually a sudden onset of cyanosis, vomiting, dyspnea, and collapse associated with an extremely rapid heart rate. Treatment is rapid digitalization. In extremely critical conditions, acetylcholine bromide may be given. This drug must be used with extreme caution, however, and an appropriate dose of the antidote, atropine sulphate, should always be on hand for immediate injection. The great advances in cardiac surgery during the past few years offer new hope for many of these infants with congenital heart disease. In these cases, our major efforts are directed toward sustaining the infant, in the hope that subsequent diagnostic procedures may reveal an anomaly which may be corrected by surgery.

### Blood Loss

Emergencies due to hemorrhage or blood destruction from various causes may be encountered in the neonatal period. Most of these conditions are extremely rare. Hemolytic anemia, hemorrhagic disease of the newborn, and hemophilia are the most important from the standpoint of early diagnosis and treatment.

#### *Hemolytic disease*

The incidence of hemolytic anemia is undoubtedly much lower in the islands than on the mainland. Its general importance, however, warrants a brief discussion. The pathologic effects

resulting from the iso-immunization of the mother to some red cell antigen lacking in her own cells is now well established. Theoretically, any of the various blood groups are capable of producing such a sensitization. Practically however, in hemolytic anemia, only the Rh factor is of clinical significance since it is the causative factor in over 95 per cent of all cases.

The diagnosis of hemolytic disease of the newborn begins with the reproductive history of the mother. Any factor which might produce iso-immunization, such as abortion, a previous Rh positive child, or the previous parenteral administration of Rh positive blood should suggest the possibility of occurrence of hemolytic anemia. Of greater significance is a history of previous stillbirth, or of previous children affected with erythroblastosis. Certain antenatal serologic data, such as the demonstration of the presence of antibodies in the blood of the mother, the type of antibody, particularly if it is of the blocking variety, and the antibody titer, are of utmost importance.

I do not wish to infer that an accurate diagnosis of hemolytic anemia may be made from reproductive histories and antenatal serologic tests. The recognition of their importance, however, often permits us to anticipate which cases are most apt to require immediate therapy.

At the time of birth the diagnosis must be made, the severity of the disease classified, and the choice of treatment determined. The essential criteria for the diagnosis of erythroblastosis are the demonstration of maternal sensitization and the presence of a positive coating reaction and anemia in the infant.

Ideal therapy for hemolytic disease of the newborn would be prevention of antibody formation by the mother. No satisfactory method of achieving this has yet been found. The next best approach is to be prepared to treat the infant immediately after birth in those instances where it is necessary and to carefully follow clinically and with blood counts those infants where it is not.

There are definite differences of opinion as to when exchange transfusions should be used. On our service at Michael Reese, we have adopted a more conservative attitude and our results compare most favorably with those of other clinics. We believe that the clinical appearance of the infant, the rapidity of onset and degree of jaundice, the presence and amount of hepatosplenomegaly and edema are the most important criteria of the infant's condition. These clinical findings, correlated with the degree of anemia, the amount of erythroblastosis, and the bilirubin content of the blood must determine when and what type of treatment, if any, is to be instituted.

I would like to emphasize the importance of the examination of the cord blood in all cases of erythroblastosis. While it is the clinical condition of the child, in our opinion, which should dictate the type of treatment to be employed, data obtained from examination of the cord blood may warn us of impending danger which, at the time, may not be manifest clinically. More and more I tend to agree with Mollison, who stresses the cord hemoglobin and red blood count as the most valuable criterion in predicting the course of the disease.

### *Hypoprothrombinemia*

Hypoprothrombinemia is considered physiological in all infants during the first few days of life. Although the prothrombin content of plasma drops during the first twenty-four to seventy-two hours after birth and only regains its initial level about the seventh or eighth day, in the majority of instances the decrease is not sufficiently great to cause a bleeding tendency to develop. The administration of vitamin K, either to the mother just before birth of the child, or to the child, will increase the prothrombin level to or above normal values. This does not, however, effect the incidence of hemorrhagic manifestations in the newborn. Obviously, there are factors other than the low prothrombin level operative in the production of many of these hemorrhagic manifestations. Acute hypoprothrombinemia is the only one which responds to vitamin K therapy. Administration of vitamin K to the mother is, of course, an effective prophylactic measure. In the treatment of the infant with vitamin K, it must be remembered that the preparations used do not produce therapeutic effect for several hours after administration. In all except the minor cases, therefore, a concurrent blood transfusion is desirable. Because of the present tendency to use the Blood Bank as a source of blood for transfusions, it should be remembered that there is a diminution in the prothrombin content of stored blood. If fresh blood is not available, do not use blood stored longer than one week.

### *Hemophilia*

In true hemophilia the normal clotting mechanism does not occur due to an absence or deficiency of thromboplastinogen which is now designated as an "anti-hemophilic globulin." The diagnosis of hemophilia does not usually present any major difficulties. A family history is not

always obtainable but, if present, will place the diagnosis beyond doubt. The important hematological features are a normal platelet count, normal bleeding time, normal prothrombin level, and a very long clotting time.

Treatment is relatively symptomatic. When hemorrhage occurs in an accessible site, local pressure is the most effective agent. Transfusions will temporarily bring the coagulation time to normal. Since the anti-hemophilic globulin is present in plasma, whole blood need be used only to correct anemia. Anti-hemophilic globulin is destroyed in stored blood. It is essential, therefore, to use blood within one or two hours of its withdrawal. In emergencies gauze dressings soaked in fresh normal blood can be used to control hemorrhage. Surgical procedures constitute a major therapeutic problem. As an immediate pre-operative precaution, a plasma or whole blood transfusion should be given and repeated at intervals of twenty-four to forty-eight hours until the danger of hemorrhage is over.

### Endocrine Disturbances

The most important emergent conditions associated with endocrine disturbances in the newborn are tetany, hypofunction of the adrenals, and hypoglycemia.

#### *Tetany*

Tetany of the newborn may produce a clinical picture similar to that of intracranial hemorrhage, congenital cerebral defect, or severe asphyxia. Its diagnosis should be considered in any newborn infant with abnormal sensitivity. The symptoms may vary in time of appearance from shortly after birth to about the thirteenth day. The clinical manifestations are varied, but among the most common are twitchings, convulsions, vomiting, edema, and cyanosis. The diagnosis is established by finding a serum calcium of 8 mg. or below. The serum phosphorus is usually elevated.

It seems likely that tetany of the newborn is the result of a physiological hypoparathyroidism. This would explain the abrupt drop in serum calcium within a few hours after birth, the low renal excretion of phosphorus in the newborn, and the exaggerated response of serum calcium to the ingestion of phosphate. It is probable, however, that there is usually, though not necessarily always, a second and precipitating factor. Such a factor might be an increase in phosphate, either released endogenously during physiologic starvation or, more likely, ingested in feedings of cow's milk. Other precipitating factors may be the occurrence of renal disease with retention of phosphorus, gastro-intestinal disturbances, or hyperventilation with respiratory alkalosis.

Since tetany may manifest itself during the course of other illnesses, we should be alert to the possibility of hypocalcemia during any seizures occurring in the newborn. Calcium chloride is the most satisfactory agent for sustaining therapy. The initial dose is two grams daily given in a 2 per cent solution, by stomach tube. After two or three days the dose is reduced. In acute conditions, one-half to one gram of calcium gluconate, well diluted, should be given intravenously. This is followed by sustaining oral therapy. Occasionally, an infant will not respond to this treatment. In such instances, dihydrotachysterol may prove of value. It is given orally in decreasing amounts beginning with two to two and one-half grams daily. Hypocalcemic tetany in the newborn may be serious. Early diagnosis and treatment with calcium is important.

#### *Adrenal Insufficiency*

The prompt recognition and treatment of adrenal insufficiency is imperative. It is most often due to a physiologic hypofunction of the adrenal cortex; less frequently to adrenal hemorrhage, and occasionally may be associated with the adrenogenital syndrome.

Infants with adrenal insufficiency are characterized by general debility and weakness, appearance of impending shock, and marked tendency to dehydration. Anorexia and vomiting are present to some degree in all patients. The vomiting at times may be projectile, suggesting pyloric stenosis. The weight loss and dehydration, however, are out of all proportion to the vomiting. The laboratory findings are quite constant. The carbon dioxide combining power is low; the non protein nitrogen elevated; there is a moderately low serum sodium chloride and an abundance of chlorides in the urine. In those cases due to adrenal hemorrhage, the symptoms are generally much more severe and the course more rapidly downhill. In these cases there may be associated evidence of an overwhelming infection or occasionally a history of an extremely difficult delivery. In the cases associated with adrenogenital syndrome, manifestations of macrogenitosomia or pseudohermaphroditism may be present.

The concept of the occurrence of a physiologic hypofunction of the adrenals in the newborn period is based on the assumption that there is a period of physiologically low activity of the true adrenal cortex. This occurs during the period

after birth when the large fetal cortex is undergoing involution and before the small true cortex has enlarged sufficiently to meet the increased need for secretion of hormones.

Such a concept could explain the poor response to stress often noted in the newborn infant and answer the question as to why certain infants fail to recover from various diseases despite the complete eradication of the infection.

Cases of physiologic hypofunction of the adrenals usually respond dramatically to the administration of desoxycorticosterone acetate. At the onset the dosage is approximate and must be raised or lowered to fit the individual case. One might start with 2 mg. daily and adjust it according to the response of the infant. Hydration must be maintained and sodium chloride given, usually 2 gm. daily, until the electrolyte balance has been regained. If weakness and listlessness persist, adrenal cortical extract should be given instead of desoxycorticosterone acetate.

In the treatment of shock, where immediate response is imperative, the intravenous injection of adrenal cortical extract is more efficacious than desoxycorticosterone. In the acute adrenal insufficiency due to adrenal hemorrhage, cortisone may be used when the hemorrhage is traumatic in origin. In cases associated with infection, however, the use of cortisone is probably unwise.

I would like to add one note of caution. The diagnosis of adrenal insufficiency has become very popular. It is possible that it is now diagnosed more often than warranted, resulting in the needless and perhaps dangerous frequent use of adrenal cortex. Before making the diagnosis of adrenal insufficiency, it would, perhaps, be wise to look for a low serum chloride or the excessive excretion of chlorides in the urine.

### *Hypoglycemia*

Symptoms of hypoglycemia in the newborn may be due to hypoglycemia in the mother or, in certain infants, result from the physiologic hypoglycemia which occurs shortly after birth. Infants born of diabetic mothers should be carefully observed for signs of edema, respiratory distress, apnea, cyanosis, and fibrillary twitchings. Hypoglycemia may produce a clinical picture resembling that of cerebral injury. Many infants born of diabetic mothers have a transiently high blood sugar which may drop during the first few hours of life. The treatment of hypoglycemia is the administration of 10-25 cc. of 10 per cent glucose intravenously. Mild cases may be managed by giving glucose by mouth. Infants with any respiratory distress are placed in oxygen. Cortisone may be of value in the severe cases.

## Gastrointestinal Anomalies

During the past few years the results from earlier diagnoses and prompt surgical intervention in certain anomalies of the gastro-intestinal tract have been most gratifying.

The most frequent of these anomalies, amenable to treatment, are tracheo-esophageal fistula, imperforate anus, intestinal atresia and diaphragmatic hernia.

### *Tracheo-Esophageal Fistula*

The diagnosis of tracheo-esophageal fistula is not difficult. The presence of an excessive amount of saliva in the mouth of the newborn infant should suggest the possibility of this anomaly. At feedings, the baby will take one or two swallows, gag, choke and vomit. This is usually followed by attacks of cyanosis. The diagnosis may be confirmed by attempting to pass a soft rubber catheter and the instillation of 0.5-1 cc. of Lipiodol. Barium sulfate should never be used when this condition is suspected because of the danger of aspiration and pneumonia.

An accurate differential diagnosis of the various forms of tracheo-esophageal fistula may be made by x-ray findings. The gas normally present in the gastro-intestinal tract of the newborn serves as an effective contrast medium.

A blind upper esophageal pouch, with a fistula between the trachea and lower esophageal segment is the most common form, occurring in about 94 per cent of the cases. In this type the x-ray will reveal Lipiodol only in the upper esophageal segment and gas in the stomach.

Delay beyond twenty-four to thirty-six hours in the surgical correction of this anomaly is associated with a marked increase in mortality.

Once the diagnosis is made, nothing is given by mouth. Pre-operative factors of importance include the administration of oxygen, antibiotics, constant aspiration of the upper esophageal segment, fluids and possibly blood. Oral feedings may be begun on the tenth post-operative day exercising extreme care and feeding the baby very slowly. Ten years ago the mortality in these cases was almost 100 per cent. Today with early diagnosis and corrective surgery, most can be saved.

### *Imperforate Anus*

There are three main types of imperforate anus. The most common consists of an imperforate anus

with a rectal pouch ending blindly some distance above. The next commonest has a proximal rectal pouch ending blindly in the hollow of the sacrum, and a normal anus ending in a distal rectal pouch. The third, and least common, is an imperforate anus with the obstruction due to a persistent membrane. These anomalies are frequently accompanied by fistulae between the rectum and the genitourinary tract or the perineum.

Examination reveals an absence of an anal opening but there is generally a dimpling and puckering of the skin in the anal area. In the type due to a persistent membrane there is a dark discoloration of the skin at the anal dimple caused by the presence of the underlying meconium.

Symptoms are an absence of meconium stools or the meconium may be passed through an abnormal outlet. After twenty-four to thirty-six hours' abdominal distension, vomiting and other signs of obstruction may occur.

At the end of twenty-four hours, x-ray examination by the Wangensteen-Rice method will aid in determining the position of the blind rectal pouch. In this technique, the infant is held head down and a lead marker is placed over the skin at the anal site. The gas present in the colon will rise and outline the blind rectal pouch, showing its location in relation to the anal site. Both anterior-posterior and lateral films should be taken. Surgical correction depends upon the anatomical relationship of the rectum to the anal site.

### *Intestinal Atresia*

Intestinal atresia when encountered requires immediate treatment. The symptoms are almost always manifest on the first day of life. Vomiting occurs and becomes progressively more frequent and severe. The vomitus is generally bile stained. Meconium stools may be small and dry. Abdominal distention together with intestinal patterning is usually a prominent feature. If the atresia is in the duodenum, the distention is largely confined to the epigastrium. If the atresia is in the jejunum or below, the distention is more generalized. The absence of cornified epithelial cells in the stools in the first forty-eight hours of life suggests an intestinal atresia. X-ray examination may be helpful in the localization of the site of the obstruction. The gas which is already in the intestinal tract serves as the best contrast medium. Barium is inadvisable because of the danger of vomiting and aspiration or of causing further obstruction.

The treatment consists of early diagnosis, preoperative decompression by means of Wangensteen suction, general supportive measures, and corrective surgery.

### *Diaphragmatic Hernia*

Before 1931, 75 per cent of patients with congenital diaphragmatic hernia died before the age of one month. Today 85-90 per cent can be cured by prompt diagnosis and surgery.

The diagnosis of congenital diaphragmatic hernia should be considered in newborn infants who present symptoms of cyanosis, dyspnea and vomiting. The cyanosis may be present at birth or may occur only with feeding or crying. It may sometimes be relieved by turning the infant so that the side with the hernia is downward, thus allowing the mediastinum to fall toward the affected side and permitting better expansion of the lung. Pulse and respiration rate are increased. Respiratory excursions on the affected side are diminished. Percussion of the involved side may reveal dullness or tympany. The heart is displaced to the opposite side. Breath sounds are distant or absent, and bowel sounds may be heard in the chest. X-ray or fluoroscopy will confirm the diagnosis. Immediate surgery is mandatory except in the occasional case with a small esophageal hernia.

## Infection

Just a word as regards infection. The availability of the antibiotics and sulfonamides should not be allowed to encourage complacency in respect to neonatal infections, nor have the advances in antibacterial therapy relieved the physician of the responsibility of prompt and accurate diagnosis. Prolonged and indiscriminate use of antibiotics may result in the emergence of a flora of resistant organisms, more troublesome than the original pathogen. The possible antagonistic effects of simultaneously administered antibacterial agents, though not very well understood at present, may prove detrimental to the patient.

Infections in the newborn may be acquired from the mother, either in utero or during birth, or they may be acquired after birth by person to person transmission of pathogens, or by physical contact with infected personnel or material. The possible role of infections acquired from pathogens present in the air is difficult to evaluate.

Of the infections acquired from the mother, syphilis is the most important. Experience of recent years has proved penicillin is a simple effective form of therapy.

After birth the umbilicus, respiratory and alimentary tracts are the main portals of entry for infective organisms.

Invasion by the umbilical route may or may not be marked by omphalitis. There may be a slight discharge from the navel which occasionally has a foul odor. The infant may appear to progress fairly well, and suddenly develop evidence of a profound systemic infection.

The clinical recognition of neonatal pneumonia is not always easy. Signs of respiratory distress—increased respiratory rate, cyanosis and fine adventitious sounds in the chest, especially when accompanied by evidence of toxemia—are very suggestive in the absence of pyrexia.

Epidemic diarrhea is probably the most dreaded of infections of the neonatal period. So far no single causative organism has been discovered. It is probably due either to a virus invading the intestines or to infection with various organisms, some of which like E. coli, paracolon and Pseudomonas are not ordinarily considered to be pathogenic.

Prevention of the disease by means of rigid cleanliness in the nursery, aseptic nursing technique, and keeping the baby away from a mother who has any infection, vomiting or diarrhea, promises the greatest protection of these infants. Immediate quarantine of a suspected subject, isolation of exposed infants and no further admission to the infected nursery are essential measures.

Once the disease has developed the treatment is purely symptomatic—withdrawal of food by mouth, parenteral fluids to restore hydration and electrolyte balance and blood and plasma to relieve the anemia and hypoproteinemia. Adequate amounts of vitamins C and B should be given. Antibiotics should be employed and an attempt should be made to isolate the causative organism.

## Summary and Conclusion

It is obvious that the further reduction in neonatal mortality is dependent upon various factors. Essentially these are: (1) increasingly efficient obstetric technique, (2) better understanding of the importance of maternal analgesia and anesthesia is predisposing to neonatal hypoxia, (3) closer cooperation between the obstetrican and the pediatrician, (4) increasing awareness on the part of the pediatrician of the importance of certain antenatal and intranatal factors in the survival of the child, (5) a better understanding of the physiology and pathology of the newborn, and (6) last, but not least, the prompt recognition and early treatment of pathologic conditions occuring in the neonatal period.

I would like to emphasize the importance of the set up of a newborn service, headed by a pediatrician who must assume the responsibility for its organization and management. The importance of preparedness and promptness in initiating indicated procedures. The importance of alert and continuous observation of all newborn infants. Not infrequently the initial impression of well being may be wrong, and the infant may develop alarming signs in the nursery, a few hours after birth. And finally, I stress the importance of accuracy in diagnosis and gentleness in the management of all newborn infants. Over-enthusiastic therapy, especially in infants suffering from asphyxia and intracranial injury, should be avoided.

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# A Note on the Fungus Flora of the Hawaiian Atmosphere

CARLYN HALDE*
DURHAM, N. C.

MOLDS are secondary only to pollen as the cause of inhalant allergy. Consequently, it is hoped that this brief report of fungus spores present in the atmosphere of Honolulu and Schofield Barracks will be of some help to the medical profession in Hawaii.



MISS HALDE

In April 1950, Dr. William A. Myers suggested to the author that mold counts would be of value for the allergists practicing in Hawaii. It was hoped that a thorough study of the fungus spores in the air might be made. However, the departure of the author from the Islands terminated this study after two months.

Beginning April 1950, plates of agar were exposed nearly daily for a month to the atmosphere at Kahala and at the Straub Clinic and for one and a half months at Schofield Barracks. Dr. Myers exposed the plates at Kahala and at the Straub Clinic. The technique was similar to that used by others on atmospheric mycological studies: a petri dish of Sabouraud's agar was opened for fifteen minutes to allow fungus spores from the air to settle on the agar surface. The fungus colonies were identified as soon as sufficient growth had taken place for identifying characteristics to be present.

The accompanying tables name the fungi most commonly found growing on the exposed plates. Only generic designation was determined. In addition to the 21 genera named in the tables, 21 other genera of fungi were identified. These, however, were isolated only once or twice, and so are not included in the tables.

The total number of colonies is recorded so that a comparison can be made of the number of spores present in the atmosphere. It was observed that Penicillium appeared in showers. For instance: on four occasions, on plates exposed at Schofield Barracks, Penicillium colonies were present in the following numbers: 480, 200, 45, 45. Otherwise, they were seen as 1-6 colonies per plate when present, with a total of 77 colonies if the showers are omitted. The showers may have been due to some form of contamination, but they occurred only with Penicillium. Showers were not seen on

TABLE 1.—*Fungi isolated from 48 plates exposed to the atmosphere at Kahala and at the Straub Clinic during April 1950.*

| NAME OF FUNGUS | NO. OF PLATES FROM WHICH IT WAS ISOLATED | TOTAL NO. OF COLONIES ISOLATED | % OF COLONIES PRESENT |
|---|---|---|---|
| Penicillium | 27 | 132 | 23.0 |
| Aspergillus | 25 | 44 | 7.7 |
| Hormodendrum | 17 | 47 | 8.2 |
| Actinomycetes* | 16 | 28 | 4.8 |
| Pullularia | 15 | 33 | 5.8 |
| Fusarium | 14 | 33 | 5.8 |
| Nigrospora | 11 | 21 | 3.7 |
| Rhodotorula | 11 | 20 | 3.5 |
| Trichoderma | 9 | 22 | 3.8 |
| Helminthosporium | 9 | 15 | 2.6 |
| Monilia† | 7 | 18 | 3.1 |
| Rhizopus | 7 | 7 | 1.2 |
| Macrosporium | 6 | 9 | 1.6 |
| Phoma | 6 | 6 | 1.0 |
| Trichothecium | 6 | 6 | 1.0 |
| Alternaria | 5 | 12 | 2.1 |
| Scopulariopsis | 5 | 5 | .9 |
| Epicoccum | 4 | 6 | 1.0 |
| Yeasts | 4 | 6 | 1.0 |
| Stemphylium | 3 | 5 | .9 |
| Miscellaneous species | | 98 | 17.1 |

* The term "actinomycetes" covers the genera Nocardia and Streptomyces.

† Not to be confused with the genus Candida which causes moniliasis.

TABLE 2.—*Fungi isolated from 39 plates exposed to the atmosphere at Schofield Barracks during April and May 1950*

| NAME OF FUNGUS | NO. OF PLATES FROM WHICH IT WAS ISOLATED | TOTAL NO. OF COLONIES ISOLATED | % OF COLONIES PRESENT |
|---|---|---|---|
| Penicillium | 27 | 77 (847)* | 20.1 |
| Hormodendrum | 23 | 90 | 23.4 |
| Helminthosporium | 12 | 27 | 7.0 |
| Actinomycetes | 10 | 20 | 5.2 |
| Nigrospora | 10 | 16 | 4.2 |
| Pullularia | 7 | 12 | 3.1 |
| Mucor | 5 | 6 | 1.6 |
| Monilia | 5 | 6 | 1.6 |
| Rhodotorula | 4 | 9 | 2.3 |
| Fusarium | 4 | 5 | 1.3 |
| Epicoccum | 4 | 5 | 1.3 |
| Phoma | 3 | 5 | 1.3 |
| Trichoderma | 3 | 4 | 1.0 |
| Macrosporium | 3 | 3 | .8 |
| Aspergillus | 2 | 3 | .8 |
| Scopulariopsis | 2 | 2 | .5 |
| Yeasts | 1 | 10 | 2.6 |
| Alternaria | 1 | 1 | .3 |
| Miscellaneous species | | 83 | 21.6 |

* See text.

* Department of Bacteriology, Duke University School of Medicine.
Received for publication January 12, 1953.

plates from Honolulu, but the Penicillium colonies varied from 1-15 per plate when present.

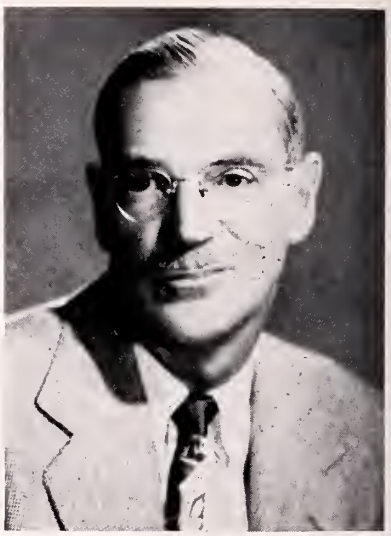
Seasonal fluctuations in the prevalence of particular fungus spores in the atmosphere have been found in most places on the mainland. Since this study took place over a relatively short period of time, it is not possible to draw reliable conclusions as to the mold population of the Hawaiian atmosphere. Nevertheless, it is shown that those fungi predominating in Hawaii are the same genera as found in other parts of the world. The most prevalent genus, however, is different. Alternaria, which has been found to be the most commonly isolated fungus in many parts of the United States, was found infrequently in the Hawaiian atmosphere. Penicillium and Hormodendrum were the two most frequently isolated genera. Nigrospora and the actinomycetes have been found to be more common than reported in many other studies. Otherwise, the fungi found in the Hawaiian atmosphere are nearly the same as reported elsewhere.

The author wishes to thank Dr. William A. Myers for his help in this study.

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# *The President's Page*

## WHAT I THINK

I think that the experience as President for the past year has been invaluable, that the cooperation and interest manifest by the members has been more than any President could expect, that I am unable to adequately express my gratitude to the many committees who have handled the ball so well when it was tossed to them, and that President Chung-Hoon should be very gratified to receive similar support.

I think that any minority group should be very active but the problems facing our Association will be so important that we must put up a united front in accordance with the majority on any issue.

I think that, because panel medicine may be less expensive, doctors must be prepared to meet the issue with a temporary reduction in fees or a temporary increase in benefits if the dignity and value of a free choice of physicians are to be encouraged.

I think that the problems associated with the time worn ethical principle that doctors treat doctors without charge could be solved immediately by the simple process of subscribing to an insurance plan where services are automatically remunerated.

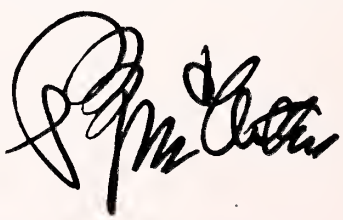
I think that it would be a step forward if all medically indigent patients were offered a free choice of physicians, doctors agreeing to take a percentage of their fees from the total amount appropriated for indigent medical care.

I think that the medical men as an organization should take a more active interest in some plan to collect outstanding accounts without creating ill will.

I think that, if we are to cope with the insidious inroads of socialization evident in the medical care of non-service-connected illnesses of veterans, we should use every expedient to urge that this service be offered only to the medically indigent veterans, and that our veterans in this group be given more to say as to where they are treated and by whom.

I think that it is a grand feeling to now be in a position to express what I think as ardently as I desire.

Aloha to an organized group of medical men of whom we can be justly proud.



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# [EDITORIALS]

## TOXOPLASMOSIS IN HAWAII

Serologic evidence for the existence of toxoplasmosis in Hawaii was first disclosed in these columns in the fall of 1950, by Dr. James R. Enright of the Division of Communicable Diseases of the Territorial Department of Health.[1] Preliminary studies sponsored by Dr. Wishik in 1944 had revealed suggestive evidence, and in 1950 Dr. Pauline Stitt, with the cooperation of Drs. Howard Crawford of Hilo and O. D. Pinkerton of Honolulu, obtained the first ten specimens of blood from children with chorioretinopathy (and their mothers) and sent them to Dr. Harry Feldman in Syracuse. Four were positive, three in significantly high titers.

Dr. Stitt's study continued, and its final results are reported in this issue of the JOURNAL, by Dr. Max Levine, Chief of the Division of Laboratories of the Territorial Department of Health, for Dr. Stitt, who has left the Territory.

This laboratory proof of the existence of toxoplasmosis in Hawaii is confirmed, also in this issue of the JOURNAL, by Dr. Irvin L. Tilden's presentation of a thoroughly-studied fatal case of congenital toxoplasmosis occurring at Waianae, on the island of Oahu.

Somewhere between the impersonal, intellectualized approach of the epidemiologic serologist and the opposite extreme, the autopsy on the fulminating fatal case, lies a field of non-fatal cases in which the alert practicing physician may hope to find, and favorably modify the course of, an occasional early case of this mysterious disease. The mode of spread of the disease—still unknown except for the transplacental one—offers a field for investigation here in Hawaii, apparently.

[1] Toxoplasmosis in Hawaii (Editorial), HAWAII MED. J. 10:37 (Sept.-Oct.) 1950.

## ALOHA TO DR. CHARLES L. WILBAR, JR.

"Charley" Wilbar was a well-qualified young pediatrician when he became, in 1943, President of the Hawaii Territorial Board of Health. We viewed his appointment, at that time, with editorial misgivings.

In 1953 we view with the deepest regret his departure from Hawaii to become assistant health executive of the State of Pennsylvania. In his ten years in office here he has, together with his executive, Dr. Richard K. C. Lee, guided the Department of Health wisely and effectively. The cordial relationship that has developed between the Department and the Honolulu County Medical Society is attested by the following resolution unanimously adopted at the Society's regular March meeting:

WHEREAS, Dr. Charles L. Wilbar, Jr., President of the Hawaii Territorial Board of Health, has diligently and competently performed the duties of that office during the many years he has occupied it; and

WHEREAS, He has been in large measure responsible for the cordial relationship that has existed between the Department of Health and the practicing physicians of Honolulu during his incumbency; and

WHEREAS, His regime has been notably and very properly free of partisan politics; and

WHEREAS, It seems possible that there is some thought of either dismissing him or accepting his resignation at this time; now therefore be it

*Resolved,* That the members of the Honolulu County Medical Society do hereby affirm their respect for Dr. Wilbar's accomplishments, and their confidence in his ability to continue to serve as the President of the Hawaii Territorial Board of Health, and be it further

*Resolved,* That they do strongly recommend to Governor Samuel Wilder King that he either permit his recently confirmed reappointment to stand, or refuse to accept his resignation if and when it is submitted; and be it further

*Resolved,* That a copy of this resolution be forwarded immediately to Governor Samuel Wilder King.

The resolution was forwarded, but in vain. Dr. Wilbar's resignation—submitted to our new Republican governor purely as a formality, since Dr. Wilbar is not a political party member—was accepted by Governor King.

On Tuesday evening, April 7, the member agencies of the Oahu Health Council sponsored a testimonial dinner honoring Dr. Wilbar, which was attended by nearly a hundred persons. At the dinner Mr. Porter Dickinson, President of the Honolulu Chamber of Commerce, read the following resolution, adopted at the last meeting of the Chamber's Board of Directors:

WHEREAS, Dr. Charles L. Wilbar, Jr., has been President of the Board of Health of Hawaii for the past ten years, and

WHEREAS, Dr. Wilbar has ably fulfilled the duties and responsibilities of this office, and has advanced public health standards in Hawaii throughout this period, and

WHEREAS, Dr. Wilbar has achieved unusual recognition, having been invited to represent the United States of America at a World Health Organization conference of health executives in Geneva, and

WHEREAS, Dr. Wilbar is leaving the position of President of the Board of Health to become Assistant Health Executive of Pennsylvania only because of a change of Territorial administration and not through any criticism of his professional work; now therefore be it

*Resolved,* That the Board of Directors of the Chamber of Commerce of Honolulu expresses its approval of Dr. Wilbar's performance of the duties of his office, its regrets that he is leaving Hawaii, and its best wishes for his success in his new position.

We are sorry to see Dr. Wilbar leave the Board of Health, and Hawaii, and we wish him success in the new and larger field to which he has gone.

## CABLE FROM GENERAL HERSHEY
### April 9, 1953

CEASE IMMEDIATELY THE PHYSICAL EXAMINATION AND INDUCTION PROCESSING OF ALL PRIORITY III PHYSICIANS WHO WERE BORN PRIOR TO AUGUST 31, 1922. ANY OUTSTANDING ORDERS TO REPORT FOR INDUCTION IN THE CASE OF PRIORITY III PHYSICIANS BORN PRIOR TO AUGUST 31, 1922 SHALL BE CANCELLED. THE PROCESSING OF ALL PRIORITY I AND II PHYSICIANS ALL AGES AND ALL PRIORITY III PHYSICIANS BORN AFTER AUGUST 31, 1922 WHO ARE PRESENTLY AVAILABLE FOR INDUCTION OR WHO WILL BECOME SO AVAILABLE UPON THE COMPLETION OF THEIR CURRENT INTERNSHIP OR RESIDENCY SHOULD BE EXPEDITED IN ORDER THAT THEY WOULD BE AVAILABLE TO FILL THE MAY AND JUNE CALLS.

## ALOHA TO ALOHA-DONTIA

*Aloha-dontia* doesn't mean "love those teeth," and it has no direct connection with fluoridation or with Hawaiian dental caries. It's the name of the new Quarterly News Letter of the Hawaii Territorial Dental Society, of which issue No. 1 of Volume 1 made its appearance under the date of March 1. It is to be issued in March, June, September and December of each year.

The Society has issued annual reports since 1937, which were mimeographed prior to 1941 and since then have been printed. They have not until now attempted a periodical publication, however.

*Aloha-dontia's* first issue runs to four 8½ by 11 inch pages, three columns to a page. Attractively printed in green ink, it contains only news items of interest to the dental profession, including an announcement of their forthcoming fifty-first annual meeting, which is to be addressed by the President and Secretary of the American Dental Association.

We welcome *Aloha-dontia* to the select group of professional publications in Hawaii, and wish it a long and successful career.

## HISTORY OF THE MABEL L. SMYTH MEMORIAL BUILDING

Excerpts from the minutes of the meetings that culminated in the successful drive to construct a permanent living memorial to the memory of the late beloved Mabel L. Smyth, back in the late 1930's, are to be found in the INTER-ISLAND NURSES BULLETIN on page 395 of this issue of the JOURNAL. They're full of interesting reminiscences, and we warmly recommend them to your attention. They are to be continued in future issues.

## "THIS IS WHAT'S NEW" CARRIES ON

Dr. Casimir A. ("Casey") Domzalski, Jr., who has enlightened and amused at least a few readers* with his sprightly and informative column, *This Is What's New,* since he began writing it in September, 1951, has been called to active duty with the Army. He had yet to finish his final three months of a two-year residency in internal medicine at the Mayo Clinic.

During his term of Army service, or at least until further notice, the column will be carried on by Dr. Fred I. Gilbert, Jr., a professional associate of Dr. Domzalski's.

* Four persons not connected with the JOURNAL are known to have commented upon the column, and on three occasions inquiries have actually been received regarding methods of treatment being reported on. This is believed to be a record.

## DR. GROVER A. BATTEN
## 1884-1953

The passing of an individual from the community in which he has lived and strived and endeavored to contribute to the welfare of its citizens is always an event of deep concern and regret. It leaves those remaining with a more acute awareness of the brief and uncertain span of terrestrial existence.

In the death of my close friend and colleague, Dr. Grover A. Batten, I know I share with all who knew him the realization that he contributed immeasurably to the happiness and physical welfare of many of the citizens of this community. Dr. Batten and I arrived in these Islands at approximately the same time, and all through the ensuing years, it was my privilege to number him among those for whom I had the greatest respect and in whom I had the greatest confidence.

He was a kind, sympathetic, understanding, cheerful physician who gave unstintingly of his time and his efforts to all those who sought his counsel. Having graduated from Johns Hopkins University where he came under the influence of the greatest physicians of that time, namely, Halsted, Osler, Welch and Kelly, he came to these Islands eminently prepared to render to its peoples the most modern and soundest medical advice known. Associating himself with the well-established firm of Drs. Herbert and Walters, having a personality that stimulated ready friendship, and possessed with energy to apply his well-recognized medical attainments, success was inevitable. Dr. Batten's interests for the betterment of Hawaii, as is well known, were not limited to his professional activities. These need not be recounted here to remind us of them.

I shall miss Grover as a friend and genial host. I shall miss his cheery, sunny disposition as will those who looked forward for his arrival from their sick beds. He never left their rooms without a word of cheer, a feeling of hope, without their not realizing with it all that he was professionally competent and they were in good hands. I shall miss his wise counsel, whether it be at the bedside, the operating table, or in relation to some policy for improving the lot of his fellow men.

His patients, who were countless, will miss him not only as an able physician, but as a sympathetic friend to whom they could turn for wise advice in time of trouble.

His family, toward whom he was a devoted husband and father, will feel the loss greatest, but will be consoled, as we all will, with the knowledge that Hawaii has benefited by his having lived among us. No one can leave a greater heritage.

J. E. STRODE, M.D.

## WAH KAI PATRICK JOSEPH CHANG
## 1891-1953

Honolulu lost both a respected man of medicine and a notable sportsman by the death of Dr. Chang on March 22, 1953. His untimely death brought to a close an unselfish, active life in the affairs of the community and a busy medical practice. Ever friendly and understanding, he gained the high regard of his professional colleagues, the lasting loyalty of his patients and the warm affection of his friends. Surviving are his wife, Mrs. Rebecca Chang; two daughters, Mrs. Edmund Wong and Mrs. William Bachran; and two grandchildren, Christopher Lawrence Bachran, 3, and Cecelia Ann Bachran, 3 months.

Dr. Chang was born in Honolulu December 16, 1891. He attended St. Louis College in Honolulu and graduated from the University of Chicago and received his M.D. degree from Rush Medical College in 1920. He returned to Honolulu to serve his internship at The Queen's Hospital. After his internship he went into private practice and shortly thereafter he married Rebecca Tam of Makawao, Maui. He was an outstanding obstetrician, besides carrying on a large general practice.

Dr. Chang was a life member of the Honolulu County Medical Society and served as its president from 1932 to 1933. He was the first Oriental elected to the American College of Surgeons. He was also a member of the Hawaii Territorial Medical Association; Hawaii Chinese Civic Association; Order of "C," University of Chicago; Pacific Club; University Club; American-Chinese Club and other groups.

Dr. Chang had a great interest in sports. He won letters in all four major sports at the University of Chicago. He was a member of the Territorial Boxing Commission and the Oahu County and Territorial AAU Boxing Committee.

RICHARD K. CHUN, M.D.

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## Recent Acquisitions

**Allergy**

Hansel, F. K. *Clinical allergy.* c1953. (gift of publisher).

Sheldon, J. M. *A manual of clinical allergy.* c1953. (gift of publisher).

**Dermatology**

Lewis, G. M. *Practical dermatology.* c1952. (gift of publisher).

**Dietetics**

Jukes, T. H. *B-vitamins for blood formation.* c1952. (gift of publisher).

Krause, M. V. *Nutrition and diet therapy in relation to nursing.* c1952. (gift of publisher).

McLester, J. S. *Nutrition and diet in health and disease.* 6th ed. c1952. (gift of publisher).

**Drugs**

Beckman, Harry. *Pharmacology in clinical practice.* c1952. (gift of publisher).

Lederle Laboratories. *The fifth year of aureomycin.* c1952. (gift of Lederle Laboratories).

Mote, J. R., ed. *Proceedings of the second clinical ACTH conference.* v.1. c1951.

**Electrocardiography**

Graybiel, Ashton. *Electrocardiography in practice.* 3rd ed. c1952. (gift of publisher).

**Gynecology and Obstetrics**

Greenhill, J. P. *Analgesia and anesthesia in obstetrics.* c1952. (gift of publisher).

Kroger, W. S. *Psychosomatic gynecology.* c1951. (gift of publisher).

Lowrie, R. J., ed. *Gynecology: diseases and minor surgery.* c1952. (gift of publisher).

**Infectious Diseases**

Leibowitz, Sidney. *Infectious mononucleosis.* c1953. (gift of publisher).

Thomas, Lewis, ed. *Rheumatic fever.* c1952.

**Medical History**

Fulton, J. F. *The great medical bibliographers.* c1951. (gift of the U. of Hawaii Library).

Petry, H. S., ed. *A century of medicine;* 1848-1948. c1952. (gift of the Medical Society of the State of Pennsylvania).

**Neurology and Psychiatry**

Alexander, Leo. *Treatment of mental disorder.* c1953. (gift of publisher).

Anderson, C. L. *Physical and emotional aspects of marriage.* c1953. (gift of publisher).

Grinker, R. R., ed. *Mid-century psychiatry.* c1953. (gift of publisher).

Heron, W. T. *Clinical applications of suggestion and hypnosis.* 2nd ed. c1953. (gift of publisher).

Munro, Donald. *The treatment of injuries to the nervous system.* c1952. (gift of publisher).

Ranson, S. W. *The anatomy of the nervous system.* 9th ed. c1953. (gift of publisher).

Sadler, W. S. *Practice of psychiatry.* c1953. (gift of publisher).

Schneck, J. M., ed. *Hypnosis in modern medicine.* c1953. (gift of publisher).

Selye, Hans. *Second annual report on stress.* c1952. (gift of publisher).

Wechsler, I. S. *A textbook of clinical neurology.* 7th ed. c1952. (gift of publisher).

**Ophthalmology**

American Academy of Ophthalmology and Otolaryngology. *Ophthalmic pathology.* c1952. (gift of publisher).

**Orthopedics**

Sarnat, B. G. *The temporomandibular joint.* c1951. (gift of publisher).

Steindler, Arthur. *Postgraduate lectures on orthopedic diagnosis and indications.* v.4. c1952. (gift of publisher).

**Pediatrics**

Hughes, J. G. *Pediatrics in general practice.* c1952. (gift of publisher).

**Tuberculosis**

American College of Chest Physicians. *Membership roster.* 1952. (gift of Am. Coll. of Chest Physicians).

Perkins, J. E. *You and tuberculosis.* c1952. (gift of National Tuberculosis Association).

**Miscellaneous**

Armed Forces Institute of Pathology. *Atlas of tumor pathology.* Sec. 111, Fasc. 9; Sec. IV, Fasc. 16; Sec. V, Fasc. 18; Sec. IX, Fasc. 34. 1950-51. (gift of Armed Forces Institute of Pathology).

Krimsky, J. H. *A doctor's soliloquy.* c1953. (gift of publisher).

Mainland, Donald. *Elementary medical statistics.* c1952. (gift of publisher).

Sattler, H. *Basedow's disease.* c1952. (gift of publisher).

Schuler, E. A. *Medical public relations.* c1952. (gift of publisher).

Walker, Harry. *Physical diagnosis.* c1952. (gift of publisher).

The Library gratefully acknowledges the gift of a number of volumes from the collection of the late Dr. Judd. For the most part these books relate to medical history and biography, and bear personal inscriptions from their authors, and for this reason are particularly interesting.

# BOOK REVIEWS

## Electrocardiography in Practice.

By Ashton Graybiel, M.D., Paul D. White, M.D., Louise Wheeler, A.M., and Conger Williams, M.D., Third Edition, 378 pp., 294 figures, Price $10.00, W. B. Saunders Company, 1952.

This is the best book in existence for the purpose of learning electrocardiology. I do not believe this opinion is influenced by the fact that I am personally fond of the authors and admire them professionally.

At the outset the theory and physiology behind recording the electromotive forces of the heart are gone into thoroughly. There is an ample discussion of artifacts and physiological variations as well as influences of drugs. To one learning electrocardiology, perhaps the most valuable portion of the book is the section devoted to "unknowns"; that is, electrocardiograms are given with a history and interpretation on a separate page so one may practice reading electrocardiograms and then have an authoritative opinion at hand. This, it seems to me, is the best way to learn to read electrocardiograms. I am sorry the practice in interpretation portion of the book has been somewhat curtailed in this third edition. Dr. Graybiel has been particularly interested in arranging the bipolar limb leads and the augmented unipolar limb leads properly in relation to the cardiac electrical fields in the frontal plane. This is discussed in some detail for those interested in the subject. All in all, as I stated at the outset, this is an excellent book.

ALFRED S. HARTWELL, M.D.

## Psychosomatic Gynecology.

By William S. Kroger, M.D. and S. Charles Freed, M.D., 503 pp., Price $8.00, W. B. Saunders Company, 1951.

The obstetrical portion of this book deals mainly with the psychological aspects of childbirth, and praises Dr. Grantly Dick Read. The authors are irked that more obstetricians do not use hypnosis. The case histories are somewhat like testimonials. The language of the psychiatrist is used freely, and there are numerous references. The gynecological section is interesting and there is much worthwhile reading as applies to everyday practice. All in all an interesting and readable book, providing one can separate wheat from chaff.

FUGATE CARTY, M.D.

## The Medical Clinics of North America.

November, 1952, Philadelphia Number—Pediatrics, pp. 1,515-1,875, incl., figs. 151-201, incl., $18.00 per clinic year cloth binding, $15.00 per clinic year paper binding, W. B. Saunders Company, 1952.

Presenting a symposium on pediatrics, this issue of the *Medical Clinics of North America* offers a well balanced choice of subjects which makes the journal desirable as a permanent reference.

Particularly noteworthy are the articles on infectious hepatitis, hemorrhagic disease, precocious puberty, noninfectious osseous lesions and undescended testicle.

DUKE CHO CHOY, M.D.

## Clinical Allergy.

By French K. Hansel, M.D., M.S., 1,005 pp., illustrated, Price $17.50, C. V. Mosby Company, 1952.

Dr. Hansel has produced a book replete with information on allergy. Every phase of allergy is covered and this necessarily makes the book somewhat lengthy. To aid its readers in understanding some of the terminology, a glossary is wisely inserted in the first chapter. References from recently published articles, including a chapter on ACTH and cortisone, are appropriately incorporated. Over 200 pages are devoted to an informative discussion of the nose and paranasal sinuses in relation to allergy. This section is a "must" for all those interested in allergy.

This book is a valuable addition to the library of anyone interested in allergy. It will be especially useful for ready references.

C. Y. SUGIHARA, M.D.

## Ophthalmic Pathology.

By Jonas S. Friedenwald, Helenor Campbell Wilder, A. Edward Maumenee, T. E. Sanders, John E. L. Keyes, Michael J. Hogan, W. C. and Ella U. Owens, 489 pp., Price $18.00, W. B. Saunders Company, 1952.

This atlas and text book of ophthalmic pathology published by the American Academy of Ophthalmology and Otolaryngology and the Armed Forces Institute of Pathology is a product or outgrowth of the old *Atlas of Ophthalmic Pathology* originally published by DeCoursey and Ash. This text book is an enlargement of the old *Atlas* and the various contributors have inserted an introductory chapter on certain basic concepts of anatomy and physiology.

The book is well written and has an excellent index system with references to the microscopic illustrations in bold face type. Microscopic illustrations are preceded by a general discussion of the latest concepts of this condition.

This book should aid the clinician as well as the pathologist in the study of ophthalmic disease.

O. D. PINKERTON, M.D.

## Pain Syndromes and their Treatment.

By James M. Tarsy, M.D., 592 pp., illustrated, Price $12.00, Charles C. Thomas, 1953.

This book adds nothing new diagnostically or therapeutically to the literature but is an excellent summary and cataloging of the various pain syndromes, with special emphasis on the neck and upper extremities. Therapeutic emphasis on local analgesic blocks, peripheral nerve, and plexus blocks as a means of interrupting pain cycles is justified on the basis of modern neuropathological concepts. With the present day emphasis on treatment of reflex dystrophies, Sudeck's atrophy, causalgias, and the intractable pain syndromes, this book is most timely.

IVAR J. LARSEN, M.D.

### Physiology of the Eye, Volume II, Vision.

By Arthur Linksz, M.D., F.A.C.S., 869 pp., Price $19.00, Grune & Stratton, 1952.

This 847-page second volume of a series of three volumes on Physiology of the Eye consists mainly of lectures by Dr. Linksz. The book does not lend itself to easy discussion. It certainly is not a book from which a practitioner can derive quick information on the visual problems which might arise in the practice of ophthalmology. It not only deals with physiology, but goes off into psychology and philosophy at times.

It might be a very acceptable book for research purposes, but even then it would take a long time for one to sit down and derive some definite meat from it. The subject of color vision has rarely been as thoroughly discussed as in this volume.

Dr. Linksz writes beautifully, and is certainly to be complimented on such an exhaustive survey of the problem of vision.

O. D. PINKERTON, M.D.

### Gynecology — Disease and Minor Surgery.

Compiled and edited by Robert J. Lowrie, M.A., M.D., D-OG, F.A.C.S., Volume I, 806 pp., illustrated, Price $22.50, Charles C. Thomas, 1952.

This, the first of two volumes, deals with gynecological diseases and minor gynecological surgery. Seventy-nine contributors of renown have made this an excellent book for gynecologists as well as for the general practitioner. It is divided into sections, starting with anatomy and physiology and ending with medications. The illustrations are excellent and contain not only diagrammatic pictures but also photographs of anatomic and microscopic specimens.

Certain sections are especially detailed and well written: anatomy; normal and abnormal development; diseases and conditions of the uterus; puerperal sepsis; benign and malignant tumors of the Fallopian tubes; ectopic pregnancy and infertility.

It is of interest to note that there is a chapter on contraception, which is so often deleted from gynecological textbooks.

On the whole this volume is an excellent book to add to any medical library.

SATORU NISHIJIMA, M.D.

### Pediatrics in General Practice.

By James G. Hughes, M.D., 735 pp., illustrated, Price $14.00, McGraw-Hill Book Co., Inc., 1952.

*Pediatrics in General Practice* derives from Dr. James Hughes' experience as a traveling postgraduate teacher in the State of Oklahoma.

The book is described as a thorough, practical reference guide for the busy physician, and it pretty capably lives up to that. The volume contains all of the conventional discussions found in the usual textbook of pediatrics. New material seems to be only the including of contemporary therapeutic agents — the "miracle" drugs, etc.

One advantage to this text is the excellent bibliography at the end of each chapter.

*Pediatrics in General Practice* is undoubtedly worth fourteen dollars if you do not have a pediatrics text in your library; however, this is no new luminary in the orbit of pediatric textbooks.

DORIAN PASKOWITZ, M.D.

### Fundamentals of Clinical Cancer.

By Leonard B. Goldman, M.D., 312 pp., illustrated, Price $8.75, Grune and Stratton, Inc., 1953.

Emphasis is placed on early diagnosis and treatment. The author is a radiologist and copiously illustrates his text with x-ray pictures, though numerous photographs of patients and gross specimens are also present. The text is arranged by organs and systems with a chapter being devoted to each. Context is brief and the salient features of symptoms, signs, diagnosis, prognosis and treatment are briefly presented, many times in tabulated form. One of the best features is the unequivocal, almost dogmatic manner in which the author presents his ideas as to therapy. However, in some instances, the truth of the brief statements is open to question. For example, the author states that the treatment of malignant cystosarcoma phylloides is radical mastectomy!!! Nevertheless, the reviewer recommends the book as excellent for a general survey of any given tumor topic or a quick reference.

RAID CHAPPELL, M.D.

### Nutrition and Diet Therapy in Relation to Nursing.

By Marie V. Krause, B.S., M.S., 562 pp., illustrated, Price $4.25, W. B. Saunders Company, 1952.

This book can be well used as a basic text in schools of nursing; it is practical, complete, easy to understand and easy to read with the exception of the food tables in the appendix, which are in too fine print for extensive reference. The organization is unusually good; each of the four sections contains information useful to student nurses.

Factors important in cookery have been included, with emphasis on the selection and quality of nutrients in a normal or therapeutic diet. The over-all objectives of meeting the physiological and psychological needs of the patient, and consideration of his sociological background, can be challenging to students.

Although this is a useful text for students it may not suffice as a reference book for the medical profession.

CYNTHIA L. W. WOLFE, R.N.

### The Treatment of Injuries to the Nervous System.

By Donald Munro, M.D., F.A.C.S., 284 pp., illustrated, Price $7.50, W. B. Saunders Company, 1952.

Here is a truly practical book which should assist greatly in the proper care of patients with injuries to the nervous system. Some neurosurgeons may disagree with the author on some points. However, the recommendations and modes of treatment set forth by Dr. Munro are the results of an experience probably unsurpassed by anyone. The instructions for proper diagnosis and treatment are simple, concise and dogmatic.

As indicated by the title, injuries to all parts of the nervous system are covered: brain, spinal cord, and nerves. Considerable space is devoted to the problems of rehabilitation. There is also an enlightening chapter on the truly phenomenal costs of medical care in paraplegia and the considerable savings which may be accomplished by rehabilitation.

The book should have a wide appeal to general practitioners and surgeons as a ready source of information in the treatment of these problems and to neurosurgeons as the considered opinion of a leader in the field.

JOHN J. LOWREY, M.D.

### Analgesia and Anesthesia in Obstetrics.

By J. P. Greenhill, M.D., 85 pp., Price $2.75, Charles C. Thomas, 1952.

In this brief monograph by Dr. Greenhill, the commonly used and newer analgesic and anesthetic agents, including hypnosis and Grantly Dick Read's technique, are discussed from an obstetrician's viewpoint. A short review of each agent or combination of agents is presented, considering three factors: (1) the potency in the relief of pain; (2) the effect on the child; (3) the effect on the mother and especially on the labor mechanism. Precautions and hazards are cited. Methods of administration are given, with those concerning caudal, saddle block, direct infiltration, and pudendal block being particularly complete.

This is another contribution to the American Lecture Series and, as such, is entirely satisfactory. There may be minor differences of opinion held by others regarding the value and usage of some of these agents, but these will be few. For the obstetrical practitioner who wants a terse, reliable outline on the subject, whether for review or enlightenment, this publication will serve his purpose well.

L. G. THOUIN, M.D.

### Gifford's Textbook of Ophthalmology.

By Francis Heed Adler, M.D., Fifth Edition, 488 pp., illustrated, Price $7.50, W. B. Saunders Company, 1953.

This small textbook on ophthalmology consists of 488 pages including the index and is an outstanding and orderly compilation of the various ophthalmic conditions and diseases in condensed form. This book should be the property of all interested general practitioners for I have not seen more ophthalmology condensed in fewer pages or so lucidly written. There are twenty-six color plates and many drawings as well as black and white pictures to illustrate the various conditions. It is practical and to the point.

O. D. PINKERTON, M.D.

### Practice of Psychiatry.

By William S. Sadler, M.D., F.A.P.A., 1183 pp., Price $15.00, C. V. Mosby Company, 1952.

This voluminous text of general psychiatry supplants two earlier versions by the same author. It has been completely rewritten and considerably enhanced by the addition of several new sections devoted to the psychosomatic illnesses. A less laudable addition is a new section devoted to Thorne's concept of "The Pathoses: the minor, pre-neurotic, attitudinal maladjustments of everyday life." It seems to this reviewer that the author's directive and admonitory platitudes will prove just as ineffective in the treatment of "pathotics" as they have always been with neurotics and psychotics, and that they have little place in modern psychotherapy.

A closing chapter gives a good critical review of previous and existing schools of thought and ends with the author's prescription for "An American School of Psychiatry," determined to rescue mental medicine from the cold storage vaults of traditional dogmas and dedicated to the formulation of a set of commonsense, middle-of-the-road principles based on the best that is known from all sources, genetic and dynamic, in the treatment of the "whole person."

WILLIAM H. STEVENS, M.D.

### Syphilitic Optic Atrophy.

By Walter L. Bruetsch, M.D., 138 pp., illustrated, Price $5.50, Charles C. Thomas, 1953.

This monograph reviews the various theories as to the cause of syphilitic optic atrophy and then presents in great detail the writer's views concerning the matter. He believes that optic atrophy is entirely dependent on an inflammatory process. Again the ghost of parasyphilis is laid. In addition to the extensive discussion concerning the cause of the condition, diagnosis and treatment are reviewed. As syphilitic optic atrophy is still a major problem, every ophthalmologist and syphilologist should profit by reading this book.

SAMUEL D. ALLISON, M.D.

## ALSO RECEIVED

### The Surgical Clinics of North America.

February, 1953, Chicago Number—Obstetrics and Gynecology, pp. 1-309, figs. 1-35, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1953.

### The Medical Clinics of North America.

January, 1953, Chicago Number—Gastrointestinal Diseases, pp. 1-293, figs. 1-32, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1953.

### Second Annual Report on Stress.

By Hans Selye, M.D., Ph.D. (Prague), D.Sc. (McGill), F.R.S. (Canada), and Alexander Horava, M.D. (Lausanne), 526 pp., Price $10.00, Acta Inc., 1952.

The general adaptation syndrome is brought up-to-date, including a discussion of 14 criticisms.

### Modern Medical Monographs — Infectious Mononucleosis.

By Sidney Leibowitz, M.D., 163 pp., Price $4.75, Grune & Stratton, Inc., 1953.

All about it with 377 references!

### Basedow's Disease.

By H. Sattler, M.D., 605 pp., Price $10.00, Grune & Stratton, Inc., 1952.

A German text on thyrotoxicosis—English translation with 3210 references.

### American Pocket Medical Dictionary.

Nineteenth Edition, 639 pp., Price $3.25 plain, $3.75 with Thumb-Index, W. B. Saunders Company, 1953.

Just what the name implies!

### Anatomy of the Nervous System.

By Stephen Walter Ranson, M.D., Ph.D., Revised by Sam Lillard Clark, M.D., Ph.D., Ninth Edition, 581 pp., illustrated, Price $8.50, W. B. Saunders Company, 1953.

Ninth edition of an excellent textbook.

### Clinical Applications of Suggestion and Hypnosis.

By William T. Heron, M.D., Ph.D., 137 pp., Price $3.75, Charles C. Thomas, 1953.

Hypnosis made easy.

### Physical and Emotional Aspects of Marriage.

By C. L. Anderson, Dr.P.H., 234 pp., illustrated, Price $4.00, C. V. Mosby Company, 1953.

### Hypnosis in Modern Medicine.

By Jerome M. Schneck, M.D., 323 pp., Price $7.50, Charles C. Thomas, 1953.

### Mid-Century Psychiatry.

Edited by Roy R. Grinker, M.D., 195 pp., Price $5.50, Charles C. Thomas, 1953.

# HMSA—Its Place in the Community

## Progress in 1952

J. R. VELTMANN, *General Manager*

HMSA held its fifteenth Annual Membership meeting on March 27, 1953, at which time the President of the Association reported that 1952 was the most successful year for the Plan, having transferred $113,413.00 to its reserves. He stated that stability of the Plan was attained in 1952—stability in management, stability of the Association's financial position and stability in the relations with doctors and hospitals.

Net membership gain for the year was 10,241 making a total membership of 63,104 members enjoying HMSA protection on December 31, 1952. This represents approximately 14% of the total population in the Territory of Hawaii and is about 30% of all persons who carry some form of pre-paid health protection. For the fourth consecutive year the Association returned to its members through payments to doctors and hospitals more than 81 cents out of every dollar received in dues income. This remarkable record is concrete evidence that HMSA is performing a great community service. Cost of operations was reduced 1.9% during the year and this is specifically attributed to improvements in the internal operations and general coordination of all phases in the Plan's administration.

Doctors' support of the Plan was further attested in 1952, when over 98% of the practicing doctors in the Territory voluntarily signed as participating physicians in the HMSA program. As an added benefit to its members, doctors voted to increase the income limits so that surgeons will accept HMSA payments as their fee for services rendered for a greater number of members.

Hospital relations were furthered when the Territorial Hospital Association designated a liaison committee to review HMSA hospital problems. HMSA plans to work closely with the hospitals so members may enjoy the best possible hospital care for the least possible cost.

HMSA management, statistical staff and various committees conduct constant studies on service costs and other pertinent factors to determine the Plan's ability to pay for services provided its members. These studies are reviewed by a national firm of actuarial consultants to prove the soundness of benefit extension. Effective January 1, 1953, HMSA has expanded its geographical coverage and has liberalized benefits for members traveling away from the Territory of Hawaii. In place of a maximum $100.00 allowance for hospital care only, HMSA now allows up to $12.00 per day for hospitalization and will reimburse the surgeon in the same amount which would have been allowed if such surgery was performed in the Territory of Hawaii. During the year additional hospital costs occasioned by rate increases were absorbed by the Association and projected into 1953. These amounts would represent approximately $21,000.00.

In the course of the year, medical care has been a subject of national interest with various proposals for some type of national legislation which were offered and considered. It is difficult to predict what type of service would be the most effective for the entire population, but today, in Hawaii, the answer seems to be in a service plan such as HMSA. In the face of rising medical and hospital costs, a service plan serves its members best, because payment is based on services rendered rather than an indemnity in terms of dollars.

*Help build Hawaii's record of donations to the American Medical Education Foundation!*

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The 378th regular meeting of the Hawaii County Medical Society was held at the Hilo Yacht Club at 7:30 p.m., February 14, 1953 with Dr. S. Kasamoto presiding. There were 19 members and 1 guest-speaker present.

A report made by the Veterans Administration Fee Schedule Committee, was accepted with the following recommendations:

a) That a study be made as to why a doctor is allowed only one-half or less hospital days when a specific number is requested.
b) That the doctor be allowed to do minor surgery in his office as removal of sebaceous cyst, ganglioma, etc., thereby saving hospital charge.
c) That the society be informed of the status of the V. A. program at least twice a year.
d) That if for any reason a doctor is charged with unethical practice, the Grievance Committee of this society be informed of this fact.

Application for membership was received from Dr. Grant Stemmermann. Transfer cards were received from Drs. James A. Mitchell and Harrison Paynter, formerly located in Honolulu.

There being no further business, the rest of the evening was turned over to Dr. E. Mayer of New York City, who spoke on the "Diagnosis and Treatment of Pulmonary Diseases."

* * *

The Annual Meeting of the Hawaii County Medical Society was held at the Hilo Country Club at 7:10 P.M., March 21, 1953, with President S. Kasamoto, presiding. Members present were: Drs. Bergin, Carter, Crawford, Hata, Hayashi, Kasamoto, Kutsunai, Loo, Miyamoto, Mizuire, Okumoto, Oto, Seymour, Steuermann, Tomoguchi, Willett, Edward Wong, Woo, Yamanoha, Yuen, Henderson, James A. Mitchel, three guests: Drs. Placio, Hieking, and McArthur.

New members Drs. Grant Stemmermann, James A. Mitchel, Richard Knotts, and Harrison Paynter were admitted to the Society by closed ballot.

Dr. Pete Okumoto gave a report on the Fred Irwin Library.

The names of officers of the Hawaii County Medical Society for 1953-1954 were presented by the Nominating Committee:

*President:* CHISATO HAYASHI, M.D.
*Vice-President:* TOSHIO KUTSUNAI, M.D.
*Secretary:* NICHOLAS STEUERMANN, M.D.
*Treasurer:* PETE OKUMOTO, M.D.

Delegates: Dr. Timothy Woo, Dr. Theodore Oto. Alternate delegates: Dr. Clarence Carter, Dr. Henry B. Yuen.

Action: By motion of Dr. A. Orenstein, the secretary was directed to cast a unanimous ballot for the slate presented by the Nominating Committee. This was seconded by Dr. Henry Yuen and passed.

Dr. H. E. Crawford was appointed chairman of the Legislative Committee.

Dr. William Bergin was reappointed delegate to the Hawaii Medical Service Association. Alternate delegate: Dr. Nicholas Steuermann.

A lengthy discussion followed regarding S. B. 273, which opposed a medical man as superintendent of the Puumaile-Hilo Memorial Hospital and further stated that the "expert" positions of radiologist and pathologist be filled according to Civil Service Classification Rates.

Action: A motion was made by Dr. A. Orenstein that the Hawaii County Medical Society go on record opposing in toto S. B. 273. This was seconded by Dr. G. Tomoguchi and passed.

After further discussion, Dr. W. Bergin made a motion that the members of the Legislative Committee of the Hawaii County Medical Society, consisting of Drs. Crawford, Orenstein, Yamanoha, Hata, and Kasamoto, be authorized to appear before the legislative members of both Houses, if necessary, to appeal regarding S. B. 273. The motion further stated that the Society would bear expenses incurred by the committee members. This was seconded by Dr. S. Mizuire, and passed by unanimous vote.

There being no further business, the meeting adjourned at 8:30.

The members then retired to the dining-room where dinner was served. For our after-dinner speaker, Dr. Kasamoto introduced Dr. McArthur of Maui, President of the Territorial Medical Association, who spoke about the physicians' economic status in the islands.

The rest of the evening was turned over to Dr. Henry Yuen, Chairman of the Program Committee, who supervised various games for everyone to enjoy.

RICHARD A. YAMANOHA, M.D.
*Secretary*

## HONOLULU COUNTY MEDICAL SOCIETY

A regular meeting of the Society was held in the Mabel Smyth Auditorium, Friday, February 6, 1953 at 7:30 p.m. Dr. Walsh presided and approximately 90 members attended. The program consisted of a movie titled "Management of Peptic Ulcer," and a lecture, "Some Psychosomatic Problems in Medicine," by Dr. A. E. Bennett, Berkeley, California, former Professor and Chairman of the Department of Psychiatry at the University of Nebraska, and Director of the Neuropsychiatric Research Foundation.

The following resolution presented in memory of Dr. Marcus Guensberg was unanimously adopted by a standing vote:

**WHEREAS, Dr. Marcus Guensberg has been an outstanding member of the Hawaii Territorial Medical Association and the Honolulu County Medical Society since October 1, 1946; and**

**WHEREAS, During this time he has contributed greatly to the mental health of the community and has done an outstanding job as Medical Director of the Territorial Hospital; and**

**WHEREAS, Dr. Guensberg died suddenly July 11, 1952; now therefore be it**

***Resolved,* That the members of the Honolulu County Medical Society do express their high esteem and appreciation of Dr. Guensberg in both a personal and professional sense; and be it further**

***Resolved,* That a copy of this resolution be spread upon the minutes of the Society; and be it further**

***Resolved,* That a copy of this resolution be transmitted to his wife, Mrs. Louise Guensberg.**

Dr. Durant, Treasurer, submitted the 1953-1954 budget as proposed by the Budget Committee. It was approved as presented.

A letter from the Hawaii Visitors' Bureau was presented to the general membership for their discussion and recommendations as to whether the Society should contribute as a unit, as requested, or whether individual donations should be made. The matter was tabled until the next regular meeting.

Dr. Gaspar stated that the public should be informed as to the opinion of the Medical Society regarding the recently proposed medical care plans, and that it is not merely a matter of dollars and cents but of quality and type of practice. After much discussion as to whether the Society should hire public relations counsel assistance and the expenses of such assistance, it was unanimously approved that the Society authorize the Public Service Committee to engage public relations counsel assistance to carry on such public relations work as is needed.

The meeting was adjourned at 11:00 p.m.

* * *

A special meeting of the Honolulu County Medical Society was held on February 20, 1953, at 8:00 p.m., in Mabel Smyth Auditorium. Dr. William Walsh presided and approximately 127 members and guests were present.

Dr. William S. Middleton, Dean of the Medical School and Professor of Medicine at the University of Wisconsin, discussed "Cardiac Emergencies."

The meeting was adjourned at 9:30 p.m. to the lanai where refreshments were served.

* * *

The Society held their regular membership meeting Friday, March 6, 1953 at 7:30 p.m. with Dr. Walsh presiding and approximately 95 members.

Dr. Paul J. Caldwell was elected to regular membership and Drs. Richard D. Smith, Lt. Cdr. Henry R. Cooper, and Lt. Donald G. Rumer were elected to associate membership.

A letter from the Hawaii Visitors Bureau requesting that the Society contribute as a unit was brought again to the attention of the membership after discussion was postponed at the previous meeting. It was moved that each member be assessed $5.00 so that a contribution may be made to the Hawaii Visitors Bureau from the Society as a unit. Although there was some objection the motion was seconded and passed.

Dr. Lyle Phillips stated that he felt a letter in place of the rather conventional resolution should be sent to Mrs. Batten expressing the sympathy of the Society in the passing of her husband, Dr. Grover A. Batten. A standing vote was held and it was unanimously passed that the following letter be forwarded to Mrs. Batten and that a copy be spread upon the minutes of the Society.

*Dear Mrs. Batten:*

I wish you to know that at their regular meeting Friday evening, March 6, the members of the Honolulu County Medical Society paused to pay tribute to the memory of their colleague and good friend, Dr. Grover Batten, your husband.

Over all the years, the doctors of Honolulu have recognized him as one in whom were typified all the fine qualities essential to a fine physician in every sense of the word,—a good citizen and a loyal and devoted friend.

The members of the Medical Society wish you to know that they share with you your grief in his passing; and also that they are most gratified that it was their good fortune to have known and worked with him during all these years.

He and his works will not be forgotten.

This message the members of the Society have directed me to send to you and your family.

Dr. Allison then gave a report of the latest activities of the Public Service Committee stating that several public relations firms were contacted and proposals received from them. He also stated that there seems to be a general opinion among the experts with whom the committee had talked and that is, an expert public relations counsel or an executive secretary could be hired for a reasonable amount. They were also in favor of starting a Collection and Credit Bureau, feeling it will benefit our Society as it has others.

Two resolutions were then presented recommending to Honorable Samuel Wilder King that Dr. Charles L. Wilbar, Jr., be reappointed to the position of President of the Board of Health. They are as follows:

WHEREAS, Dr. Charles L. Wilbar, Jr., President of the Hawaii Territorial Board of Health, has diligently and competently performed the duties of that office during the many years he has occupied it; and

WHEREAS, He has been in large measure responsible for the cordial relationship that has existed between the Department of Health and the practicing physicians of Honolulu during this incumbency; and

WHEREAS, His regime has been notably and very properly free of partisan politics; and

WHEREAS, It seems possible that there is some thought of either dismissing him or accepting his resignation at this time; now, therefore be it

*Resolved,* That the members of the Honolulu County Medical Society do hereby affirm their respect for Dr. Wilbar's accomplishments, and their confidence in his ability to continue to serve as President of the Hawaii Territorial Department of Health, and be it further

*Resolved,* That they do strongly recommend to Governor Samuel Wilder King that he either permit his recently confirmed appointment to stand, or refuse to accept his resignation if and when it is submitted; and be it further

*Resolved,* That a copy of this resolution be forwarded immediately to Governor Samuel Wilder King.

The Honolulu County Medical Society unanimously expresses its satisfaction with the manner in which Dr. Charles Wilbar has conducted the office of President of the Board of Health, and recommends that he be reappointed to that position.

The meeting was adjourned at 10:30 p.m.

C. M. BURGESS, M.D.
*Secretary*

* * *

The annual meeting of the Honolulu County Medical Society and the Honolulu County Medical Library was held in the Mabel Smyth Auditorium April 3, 1953 with Dr. William M. Walsh presiding and approximately 70 members present.

Dr. Robert Faus presented a resolution in memory of Dr. Wah Kai Chang. The resolution was unanimously passed by a standing vote of the membership. It is as follows:

WHEREAS, Our beloved member of the Hawaii Territorial Medical Association and Honolulu County Medical Society died March 22, 1953, now therefore be it

*Resolved,* That his wife and family be informed that the Honolulu County Medical Society feels keenly the loss of this invaluable member who has throughout his life exemplified the spirit of the true Physician in his practice for more than thirty-five years. His integrity, sterling character, honesty, steadfastness and devotion to Duty, God and Country are an example we all hope to emulate.

His sportsmanship was a guiding light to the athletic world and was frequently cited by Alonzo Stagg, his former coach at the University of Chicago.

His citizenship was a monument to Hawaii's product of Statehood eligibility.

His leadership was an example of tact, fairness and resourcefulness.

Hawaii has lost a great citizen and physician.

May God receive, rest and recognize his soul as the type to inherit this earth.

The report of the Treasurer was then read with the recommendation that the series "D" bonds having a cost of $6,000.00 which matured in November, 1952 be liquidated and the proceeds reinvested unless the Society plans for other use of this fund. Dr. Dickson then moved that action concerning the Series "D" bonds be referred to the next Board of Governors meeting. This was seconded and carried unanimously.

Dr. B. Allen Richardson, President of the Library Board of Governors, presented his report. He then read

a letter from the Board of Management of the Mabel Smyth Building stating that they have not been able to meet expenses and that as of April 1, 1953 a charge of $375.00 per month will be made for the space occupied by the Library and Stacks. Dr. Arnold moved that the Library be advised to reply that the Library has no funds and that any further communications regarding the matter be referred to the Honolulu County Medical Society. Dr. Morton Berk seconded the motion whereupon it carried.

The following reports were then given:

Secretary's Report—Dr. Clarence M. Burgess
Library Committee Report—Dr. John Peyton
HMSA Representative's Report—Dr. Lyle G. Phillips
Preparedness Committee Report—Dr. Robert Faus
Committee on Forms of Medical Practice—Dr. Robert B. Faus
Fee Adjustment Committee—Dr. Thomas H. Richert
Program Committee Report—Dr. John M. Felix
Legislative Committee Report—Dr. B. Allen Richardson
Woman's Auxiliary Report—Mrs. Thomas Fujiwara
Postgraduate Committee—Dr. John Bell
Grievance Committee—Dr. C. C. McCorriston
Malpractice Committee Report—Dr. I. Kawasaki
Public Service Committee Report—Dr. T. Nishigaya
President's Address—Dr. William M. Walsh

The election of officers was held, and the following were elected:

*Officers:*
President—Dr. William S. Ito
Vice-President—Dr. Clarence M. Burgess
Secretary—Dr. Richard C. Durant
Treasurer—Dr. John M. Felix

*Board of Governors* (for two years):
Dr. H. Q. Pang
Dr. Francis D. Nance
Dr. Verne C. Waite
Dr. H. M. Patterson

*Alternates—Board of Governors* (1 year):
Dr. Robert F. Bailey
Dr. C. C. McCorriston
Dr. Robert T. Wong

*Board of Censors* (3 years):
Dr. Clarence E. Fronk

*Committee on Forms of Medical Practice* (for five years):
Dr. William M. Walsh

*Delegates to Hawaii Territorial Medical Association* (for two years):
Dr. Duke Cho Choy
Dr. Laurence Wiig
Dr. John Kometani
Dr. James G. Marnie
Dr. Paul Gebauer
Dr. Robert Bailey

*Alternate Delegates to the Hawaii Territorial Medical Association* (for two years):
Dr. Tell Nelson
Dr. Thomas Y. K. Chang
Dr. Fred Gilbert Jr.
Dr. Walter Quisenberry
Dr. Edmund Ing
Dr. L. Q. Pang

*Representatives to HMSA* (2 years):
Dr. H. Q. Pang
Dr. Robert G. Johnston
Dr. Rodney T. West

*Fee Adjustment Committee* (3 years):
Dr. B. Allen Richardson
Dr. Tadao Hata
Dr. Dean Walker

The new President, Dr. William S. Ito, then addressed the membership, after which he adjourned the meeting to the lanai for refreshments at 10:45 p.m.

* * *

The Honolulu County Medical Society held two joint meetings with the Institute on Prematurity on April 6 and April 13 at 7:30 p.m. in the Mabel Smyth Auditorium. All hospital administrators, physicians, and nurses were invited to attend these meetings on the obstetrical and pediatric aspects of prematurity. The program of April 6 consisted of the following topics: "Prevention of Prematurity," Dr. H. E. Bowles; "Medical Aspects—Labor and Delivery," Dr. L. Bachman; "Significant Points in Nursing Care," Miss E. Tschida. The program of April 13 concerned pediatric considerations in prematurity. "Care of the Newborn Premature—Resuscitation, Feeding, etc.," Dr. E. Lum; "Physician Aspects and Complications," Dr. J. Peyton; "Significant Points in Nursing Care," Miss E. Tschida; "Follow-up of the Premature," Dr. D. C. Choy.

RICHARD C. DURANT, M.D.
*Secretary*

## MAUI COUNTY MEDICAL SOCIETY

The monthly meeting of the Maui County Medical Society was held at Central Maui Memorial Hospital on March 10, 1953, at 8:00 p.m.

There were 17 members and 3 guests present.

An application for membership was received from Dr. Mei but as he does not have a Territorial medical license, this was filed until such time as he becomes eligible for membership. Dr. Mei was invited to attend all medical society meetings as a guest during this interim period.

A communication from Dr. Reppun was read, regarding the filling out of medical forms and release of confidential information to employers without patient consent. Considerable discussion followed, during which Dr. McArthur suggested that this matter be referred to our Councilor to take up at the Territorial meeting. It was also moved that the letter be acknowledged and filed. This motion was defeated. It was then moved by Dr. Izumi, seconded by Dr. Ferkany, that the Secretary write to the employer concerned regarding the ethics of releasing confidential information of patients. This motion carried.

A communication from the Central Maui Memorial Hospital staff was read, about their action and recommendation regarding a physician on the Managing Board of the hospital. The letter was received from Dr. Izumi, President of the staff, and the opinion of the Society was requested. Dr. Izumi stated during discussion that the President and Secretary of the staff should be on the Managing Board in an advisory capacity only and not have a voting privilege. This would make for a closer relationship between the Managing Board and staff and would also be of great assistance when disciplinary problems arise. Dr. Patterson moved and Dr. Underwood seconded a motion that the Society recommend and concur in the wishes of the active staff regarding this matter. Motion carried—Yes—7; No—0. Several not voting.

Dr. Burden brought up the matter of the resignation of Dr. Charles Wilbar as President of the Territorial Department of Health. After much discussion, it was moved by Dr. Patterson, seconded by Dr. Underwood,

that a letter be written from the Society to Dr. Wilbar, expressing our confidence in his ability, our approval of his work and past actions and our satisfaction with his past administration of the Department of Health. Copies are to be sent to Governor King and to the Maui Republican Patronage Committee, in care of Mr. Mizuha. Motion unanimously carried.

Dr. McArthur brought up the matter of payment of fees under the new Longshoremen's Medical plan, payment being made to the patient rather than directly to the physician. It was moved, seconded and carried that the Society refer this matter to the Public Relations Committee, requesting that they investigate the possibility of having payment made directly to the physician rather than to the patient.

President Burden called for a report of the Nominating Committee. The report was given by Dr. Shimokawa as follows, for officers of the Society—1953-54:

*President*—EDMUND TOMPKINS
*Vice-President*—LOUIS ROCKETT
*Secretary-Treasurer*—HAROLD KUSHI
*Delegates*—ALFRED BURDEN
K. IZUMI

Dr. Sanders moved and Dr. McArthur seconded a motion that the nominations be closed and the secretary instructed to cast a unanimous ballot for the slate as named. Motion carried.

The meeting adjourned at 10:30 p.m.

* * *

A breakfast meeting of the Maui County Medical Society was held at the garden of the Maui Grand Hotel on Sunday morning, February 15, 1953. Those in attendance were: Drs. Underwood, Cole, Patterson, Wong, Kashiwa and Burden, with County Health Officer Dr. Mei, as guest.

Three communications from H.M.S.A. were read by Dr. Burden, one regarding the status of laboratory work in obstetrical cases, stating that this need not be included in the obstetrical fee of $100.00 which is allowed at the present time, physicians being at liberty to charge patients for these services. The second letter concerned the status of H.M.S.A. negotiations relative to a medical contract with the longshore group. The third letter was a request for recommendations of names to serve as Directors on the H.M.S.A. Board for the years 1953 to 1955, to be submitted to the nominating committee prior to March 5. With the unanimous consent of the membership present, the names of Dr. Underwood for Director and Dr. Wong for alternate will be submitted.

Following the short business session, the meeting was turned over to Drs. Peyton and Kobayashi from Honolulu for a discussion of pediatric problems.

EDMUND TOMPKINS, M.D.
*Secretary-Treasurer*

* * *

A special meeting of the Maui County Medical Society was held on April 6, 1953 at the Central Maui Memorial Hospital to hear Mr. J. R. Veltmann speak on the proposed Pineapple Medical Plan.

Those present were Doctors Tompkins, Izumi, Kashiwa, Sanders, Wong, Underwood, McArthur, Ohata, Rose, Tofukuji, Kanda, Haywood and H. Kushi.

After a short discussion it was moved by Dr. Sanders that the Maui County Medical Society go on record as favoring the 10 per cent withholding from fees derived from the Pineapple Medical Plan if the HMSA plan is accepted. It was seconded by Dr. Haywood and passed unanimously.

Dr. Izumi then moved that the Society also go on record as favoring a 10 per cent withholding from fees derived from all plans so that more benefits can be given to its members in the future. Motion seconded by Dr. Underwood and passed unanimously.

* * *

A regular meeting of the Society was called to order by President Tompkins on April 14, 1953 at the Central Maui Memorial Hospital. Present were: Doctors Rockett, Ferkany, Izumi, Kashiwa, Tofukuji, Tompkins, Wong, Cole, Ohata, McArthur, Underwood, Patterson, Kanda, Burden and H. Kushi. Guests present were: Mrs. Edith Bennett, Mrs. Izumi and Mrs. Cole of the Medical Auxiliary.

Mrs. Bennett gave an enthusiastic report on the coming annual Territorial Medical meeting to be held on Maui. From the latest figures approximately 160 doctors and wives are expected to be present from the outside islands. Final details of the meeting were ironed out and questions pertaining to the meeting were answered by Mrs. Bennett. It was also requested that the Maui doctors fill out the forms sent out by her office and return same to Honolulu.

A letter from Dr. Miura requesting that the doctors conduct a panel on cancer on a radio program was read. The matter was referred to the Cancer Committee.

Letter from Dr. Charles Wilbar thanking the Society for the confidence shown in him during his past Board of Health regime was read.

A letter from Dr. Phillips, chairman of the HMSA medical committee, was read in regard to their plan and recommendation that the HMSA medical committee be a part of the industrial relations committee of the Territorial Medical Association. The matter was tabled on motion by Dr. Cole, seconded by Dr. Underwood and passed unanimously.

Dr. Tompkins, president of the society, made the following appointments for the fiscal year 1953-1954:

*Program Committee:* Dr. Patterson, chairman; Drs. McArthur and Ohata, members.
*Publicity Committee:* Dr. H. Kushi, chairman; Dr. Rockett, member.
*Cancer Committee:* Dr. Cole, chairman; Drs. Ferkany and Wong, members.
*Blood Bank Committee:* Dr. Wong, chairman; Drs. Shimokawa, Tompkins and St. Sure, members.
*Medical Economics & Public Relations Committee:* Dr. K. Izumi, chairman, Drs. Sanders and Haywood, members.
*Procurement Committee:* Dr. Underwood, chairman; Drs. Burden and Cole, members.
*Fair Committee:* Dr. Tofukuji, chairman.
*4th of July Carnival Committee:* Dr. Ohata, chairman.

HAROLD S. KUSHI, M.D.
*Secretary*

# NOTES AND NEWS

## PERSONALS

**Dr. and Mrs. Maurice Gordon** returned from an extended trip to the Mainland and abroad. While in Europe they visited the British Isles, Holland, Belgium, France, Spain, Portugal, Germany, Austria, Italy, Switzerland, and Greece. They also went to Israel.

**Dr. Charles Wilbar** has resigned as President of the Territorial Board of Health to become Assistant State Health Officer of the State of Pennsylvania.

**Dr. Frank H. Hatlelid** is leaving in April to attend the Industrial Medical Conference in Los Angeles.

**Dr. Phillip M. Corboy** addressed the Rotary Club of Honolulu on the subject "Communism in Hawaii—What to Do About It."

**Dr. W. H. Wilkinson,** formerly of Lanai City, Lanai, has moved to Wahiawa where he will act as physician for the Hawaiian Pineapple Company. He is replacing **Dr. Joseph T. Lucas** who has been recalled to duty with the Navy.

**Dr. H. C. Gotshalk** won the match play against par at the Waialae Country Club.

**Dr. Edmund L. Lee** returned from the Mainland. At St. Louis Dr. Lee attended the meeting of the American Academy of General Medicine.

The 1954 meeting of the Pacific Coast Oto-Ophthalmological Society will be held in Honolulu April 25 to 29, 1954. Chairman for arrangements is **Dr. Clarence Trexler.**

**Dr. and Mrs. Francis D. Nance** left in April for an extended tour of Europe. In France Dr. Nance is slated to address the Pediatric Society of Lyons.

**Dr. Harold Johnson** will read his inaugural paper on splenectomy in systemic lupus erythematosus at the annual meeting of the American Dermatological Association at Lake Placid, New York, in June.

**Dr. V. C. Waite** gave two post-graduate lectures in the field of proctology at the University of Minnesota, by invitation, in April.

Due out in June is **Dr. Harry Arnold, Jr.'s** monograph entitled "Modern Concepts of Leprosy." Also by Dr. Arnold, in *Current Therapy, 1953,* is an article on the treatment of skin cancer.

**Dr. Garton Wall** left to attend the meeting of the Policy Board of the Naval Reserve Officers in Washington as the representative of the Fourteenth Naval District.

**Dr. and Mrs. L. Q. Pang** are leaving to attend the annual meeting of the Triological (otologic, rhinologic and laryngologic) Society to be held in New Orleans. Following this meeting they are embarking on a trip to Europe. The highlight of their European tour will be the meeting of the International Congress of Otolaryngology to be held in Amsterdam in June.

**Dr. Rodney T. West** has been elected chairman of the medical executive committee and chief of staff of Kapiolani Maternity and Gynecological Hospital. Dr. West left in April for the Mainland where he will attend the meeting of the American Fertility Association in New York.

**Dr. Peter J. Washko** has been elected to the American Roentgen Ray Society.

**Dr. Joseph E. Strode** and **Dr. C. M. Burgess** recently returned from the Mainland where they attended meetings of the American Association for Thoracic Surgery and the American Surgical Association.

**Dr. Robert Bailey** has been elected as President of the Hawaii branch of the American Academy of General Practice.

**Dr. and Mrs. Joseph Strode** left for a six weeks trip to Japan. They will visit their son, Walter, who is on the urologic service of the 279th General Hospital at Osaka.

**Dr. Bernard Schultz** has accepted the position of senior medical officer at the Veterans Hospital in Montgomery, Alabama and was scheduled to leave the Islands in the early part of May.

**Dr. Thomas Bennett** left for a trip to Mexico, Yucatan and Cuba on the way to attend the meeting of the Harvey Cushing Neurosurgical Association in Miami in April.

**Dr. Paul Gebauer** returned from meetings of the American Association of Thoracic Surgery and the American Surgical Association. At the former he gave a paper on the subject of bronchial resection and anastomosis.

**Dr. Clarence Trexler** will attend the Pacific Coast Oto-Ophthalmological Society's meeting to be held in May in Los Angeles.

St. Francis Hospital announces the addition of **Dr. Rasmee Hasitevej** to its resident staff. Dr. Rasmee is a graduate of Siriraj School of Medicine, Bangkok, Thailand.

**Col. Austin Lowrey,** Chief of the Department of Ophthalmology at Tripler Army Hospital, recently returned from a trip to the Mainland. He gave a series of lectures on ocular motility at the Percy Jones Army Hospital in Battle Creek, Michigan, and also attended the annual Residents Association meeting at the Wilmer Eye Hospital in Baltimore.

**Capt. Harold Weaver** is being transferred to the Great Lakes Naval Hospital as Executive Officer. Presently Capt. Weaver is medical officer in charge of the Navy medical unit at Tripler Army Hospital.

**Dr. Charles Bratenahl** has recently arrived to assume the duties of pathologist at Tripler. Dr. Bratenahl is a graduate of the University of Pennsylvania School of Medicine and interned at the National Naval Medical Center, Bethesda, Maryland. He received his training in pathology at the National Naval Medical Center, Bethesda, and the University of Michigan. Dr. Bratenahl is certified by the American Board of Pathology in tissue pathology. Prior to his duty in Hawaii, he was stationed at the Naval Hospital in Key West, Florida. Dr. Bratenahl is married and has a daughter.

**Capt. Ferris W. Thompson,** kamaaina practitioner, who at present is senior medical officer at the Pearl Harbor Navy Yard, has been transferred to a similar position at the Long Beach Navy Yard.

**Dr. Alexander (Sandy) Thompson** is now assisting **Dr. Herbert Rothwell** at Kahuku Plantation Hospital. Dr. Thompson is a graduate of McGill University and has interned at Queen's Hospital.

**Dr. and Mrs. George Ewing** announce the birth of a daughter, their first child, born on February 27.

In the last issue of this column it was inadvertently stated in error that **Dr. Herbert Y. H. Chinn's** past medical training had included one and a half years of residency at the State University Medical Center at New York. It should have been stated that after two and a half years of military service, Dr. Chinn returned to Kings County Hospital in Brooklyn, New York, for three and a half years of further urological training, the last year and a half of which he spent as chief resident on the urological division of the State University Medical Center at New York.

**Dr. Richard D. Kepner** and family left Honolulu May 15 for a combined business and vacation trip. In England, Dr. Kepner will attend the annual meeting of the Royal Medico-Psychological Association, of which he is a member. He has been invited to speak in India and in Thailand. He will return to Honolulu with his family on September 1.

Retiring after 46 years of practice in Hawaii is **Dr. Homer Hayes.** Dr. Hayes was a graduate of Cooper Medical College, Class of 1906, which later became Stanford University School of Medicine. He was the first to intern at Queen's Hospital. Following his internship he was appointed as county physician at Molokai for eight years. He was then appointed as the first county physician for Honolulu. As soon as the doctor winds up his affairs, he is planning to retire in the Kona district in Hawaii.

**First Lieutenant Robert K. Mookini, Jr.** was the first Priority III doctor to be called into active service from Hawaii. **Captain H. Joseph Simon** and **First Lieutenant Sheldon Cholst** are now in the Army. **Lieutenant Joseph T. Lucas** of the Naval Reserve was recalled to active duty.

Due to join the Fronk Clinic June 1 is **Dr. Andrew C. Ivy, Jr.,** son of the well known **Dr. Ivy** in Chicago. A graduate of Northwestern University Medical School, he had a year's surgical internship at the University of California Hospital, followed by two years at Kahuku Plantation with **Dr. Rothwell.** He left Hawaii for a year of general surgical residency at Hines Veterans Hospital in Chicago. Since July 1951 he has been in the Army, spending the last 18 months with a mobile surgical unit in Korea.

**Captain Rowlin L. Lichter,** son of **Dr. M. H. Lichter,** recently completed a 2 year assignment with the Army Air Force and is currently stationed at Lowry Air Force Hospital, Denver, Colo. As a medical officer in the Air Force, Dr. Lichter has been assigned to Fitzsimmons Army Hospital for a six year orthopedic residency.

## Hawaii

New members: **Drs. Grant N. Stemmermann, James A. Mitchel, Richard Knotts,** and **Harrison Paynter** were admitted to the Hawaii County Medical Society.

**Dr. James A. Mitchel,** chest surgeon of Puumaile Hospital, announced his association with **Drs. Orenstein** and **Bergin.**

The House of Representatives of the Territory of Hawaii held a public meeting on March 27, 1953 at the Hilo Intermediate School auditorium. Members of the Hawaii County Medical Society, as well as the public expressed their opposition to Senate bill No. 273, which would have prohibited any physician from being administrator at Hilo Memorial Hospital or Puumaile Hospital.

## Kauai

**Dr. William Goodhue** attended the Industrial Medical Association Convention held at Hotel Statler in Los Angeles, California during April 20-24.

**Dr. Frank Sykes** is now assisting **Dr. William Goodhue** at the McBryde Dispensary. He returned from the Trust Territories physician position in Yap to assume his new responsibility. On March 29, 1953, he also became the proud father of a bouncing baby boy.

**Col. Carl M. Rylander** of Tripler Hospital gave a talk on the "Common Errors in Orthopedics" at the Wilcox Hospital Medical Staff meeting on April 7, 1953.

## Maui

**Dr. Robert Rose** has joined the staff of the Pioneer Mill Hospital. He comes from New York, having been in private practice in Bakersfield, California, after serving in the Navy. He is married and has one child.

**Dr. Wilkinson** of Lanai, has transferred to Wahiawa to replace **Dr. Lucas. Dr. Knox** who has been associated with Dr. Wilkinson will carry on on Lanai.

**Dr. Joseph Ferkany** has left for the mainland where he will attend the Thoracic Surgeons Meeting in San Francisco. He will be gone for about three weeks.

We are pleased to welcome **Dr. Robert L. McArthur,** older brother of **Dr. R. J. McArthur,** president of the Territorial Medical Association. Dr. Robert McArthur hails from Portland, Oregon, where he specialized in OB and Gyn.

# NEWS

## X-Ray Technicians School

St. Francis Hospital has received approval for its School for X-Ray Technicians from the Council on Medical Education and Hospitals of the American Medical Association.

Under the direction of **Dr. Richard D. Moore,** the Radiologist, the Program will accept two students each year in September. Students will be eligible for examination as Registered Technicians upon the completion of the two-year course. The School is licensed by the Department of Public Instruction.

# UMI MAKAHIKI I HALA*

### Continuous Caudal Anesthesia Is Not Safe — Yet

Caudal anesthesia may yet prove a valuable addition to our obstetrical armamentarium but it will require much more research before it is put to general use and then only with a full understanding of its limitations and risks. I doubt now whether it will stand the tests of time.

O. Lee Schattenburg, M.D.

### Promin F

Will any of the sulfonamides prove of value in the treatment of tuberculosis? Experimental work has suggested that Promin may have some value in this disease but clinical confirmation so far has been lacking.

### Penicillin

. . . much more investigative work will be necessary before the place of Penicillin in our therapeutic armamentarium is established.

S. E. Doolittle, M.D.

### Emergency Medical Services Report

. . . The recent return of many functions of government to civil authorities has presented many serious medical problems in that no substitutes are available for the Army personnel which carried on many of these functions. At the time of this report I am assured by the Department Surgeon that, until further action is taken, these doctors and nurses will not be disturbed in their present duties. This is, of course, not a promise for the future, but good for the time being. Owing to the extremely able assistance of Major Chung-Hoon, who has been in this office since July, 1942, your chairman was able on the first of the year to assume a half-time volunteer status and devote a portion of his time to practice. It is impossible to overstate Major Chung-Hoon's value to this office. His intimate knowledge of the Territory as a whole and of the doctors and hospitals in it has made him more useful than any malihini could have been. We medical men are deeply indebted to the Army for his services. Dr. Dickson who has been in charge of the aid stations and ambulance service has likewise gone on a part-time basis and Major Chung-Hoon is carrying some of his responsibilities also.

H. L. Arnold, M.D.
*Territorial Medical Director, O.C.D.*

### Hawaii County Medical Society

. . . After considerable discussion, it was moved by Dr. Keay, seconded by Dr. Phillips, that the Society be unalterably opposed to the lowering of qualifications for the position of Territorial Commissioner of Public Health, as proposed by Senate Bill No. 92.

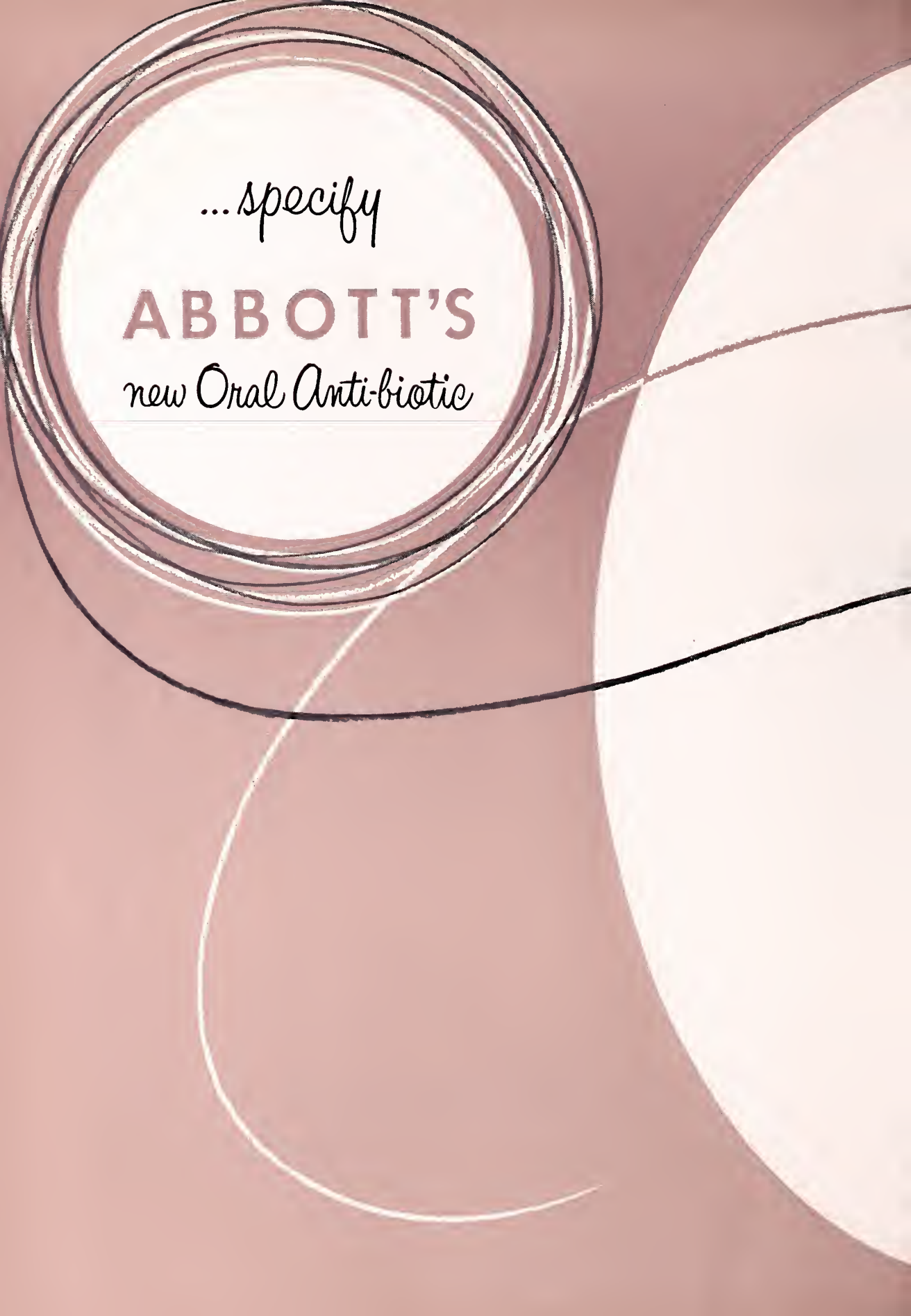
### The Medical Milk Commission Report

. . . If, as a general precautionary safeguard, it was thought wise to protect the city's water supply by chlorinating it, is it not equally logical to protect the milk supply of the city by pasteurizing it? The Commission believes that it is, and makes this recommendation to the Honolulu County Medical Society, leaving to the parent body whatever action it may deem advisable.

William Winter, M.D., Chairman

* Ten years ago. From Volume 2, Number 5, May-June, 1943.

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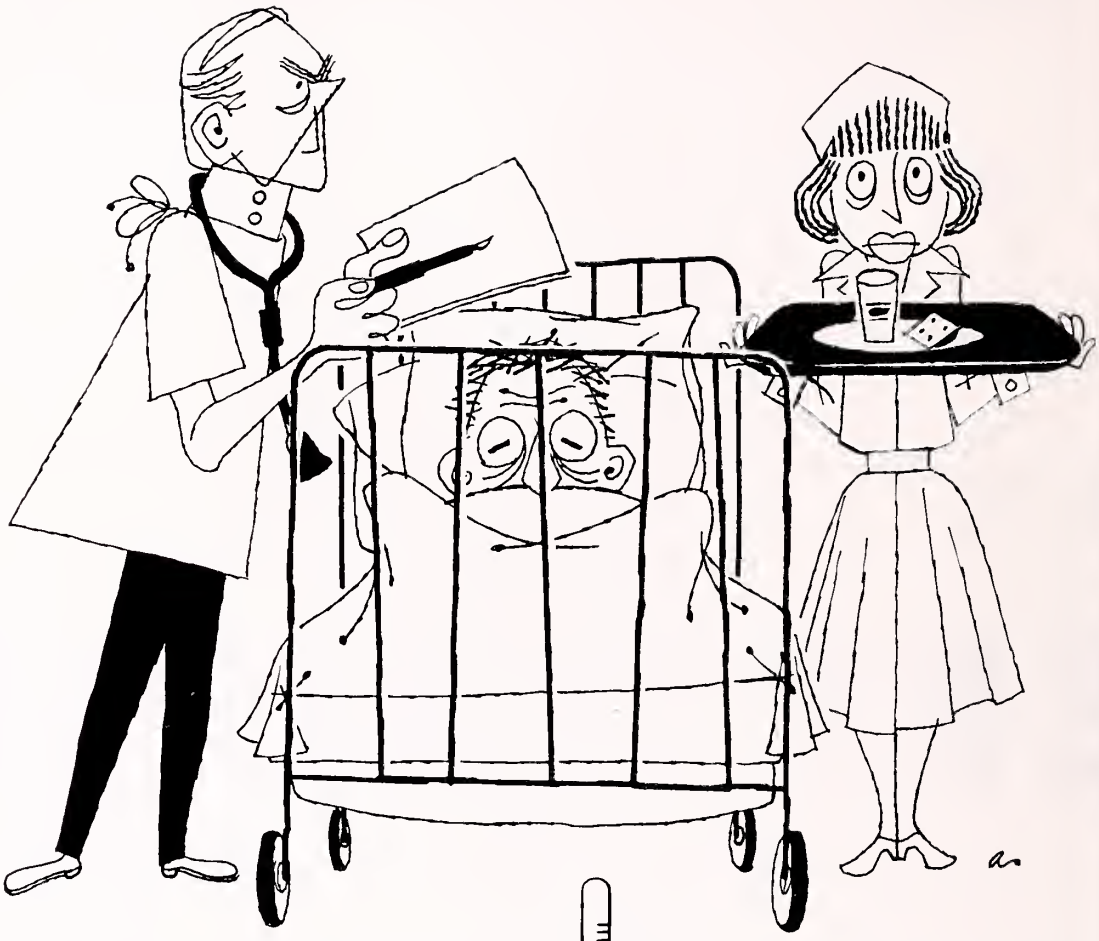
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**INDICATIONS** Pharyngitis, tonsillitis, scarlet fever, erysipelas, pneumococcic pneumonia, osteomyelitis, pyoderma. *Also other infections caused by organisms* susceptible to its action, including staphylococci, streptococci and pneumococci.

**DOSAGE** Total daily dose of 0.8 to 2 Gm., depending on severity of the infection. A total daily dose of 0.6 Gm. is often adequate in the treatment of pneumococcic pneumonia. *For the average adult* the initial dose is 0.2 Gm. to be followed by doses of 0.1 or 0.2 Gm. followed by doses in the same range every four to six hours. *For severely ill patients* doses up to 0.5 Gm. may be repeated at six-hour intervals if necessary. Satisfactory clinical response should appear in 24 to 48 hours if the causative organism is susceptible to ERYTHROCIN. Continue for 48 hours after temperature returns to normal. Abbott

1. McGuire et al. (1952), J. Antibiotics & Chemo., 2:281, June.
2. Heilman et al. (1952), Proc. Staff Meet. Mayo Clin., 27:385, July 16.
3. Haight and Finland (1952), New Eng. J. Med., 247:227, Aug. 14.



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# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAM, *Executive Secretary,* Honolulu

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## PRESIDENT'S MESSAGE

The yearly Advisory Council meeting of the American Nurses' Association is the sounding board for developments and progress in nursing. The presidents and executive secretaries of the constituent states and territories meet with the officers, board of directors and staff of this organization which represents 177,085 member nurses in the United States. Common problems and pitfalls are discussed. The nurse, as an individual, is not a forgotten entity in this massive association. Preparation for a career in nursing, opportunities in chosen fields, welfare and security are scrutinized, studied and statistically evaluated. Recommendations and programs are outlined. The nurse is benefited. The consumer of nursing, John Q. Public, derives the benefit from this combined thinking and implementation of good nursing programs. The community is served in a special way.

Years of concentration and research have proved the need for a change in our structures. This has been effected. Now we have two main branches in nursing—The American Nurses' Association and the National League for Nursing. The big question is "why the emphasis on SECTIONS in the American Nurses' Association?" The national association has long realized that nurses complain in a chronic way that some evanescent group sets up criteria for qualifications for positions and personnel policies and practices. It is aware that nurses have complained that their special interest group has been pushed to the background. These are reasons why the American Nurses' Association has seen wisdom in the formation of sections. You, now, have the opportunity to express your views and opinions regarding policies and practices in your particular field. You, now, have the opportunity to vitalize so-called inanimate hypotheses. This is your opportunity to write your own ticket.

The goal of a strong organization should not be sidetracked by the formation of little groups who aspire to individual power and destroy the good of the whole. We must remember the good wiseman who showed his son how simple it was to snap a single twig but how difficult it was to bend a bundle of twigs which had been bound together.

ELIZABETH MCCALL, R.N.

## ETHNIC FACTORS IN THE NURSING CARE OF JAPANESE PATIENTS

SHIRLEY GIMA*

In the study of the cultural patterns of a racial group in relation to the nursing problems involved, one must recognize the fact that the first generation resists change which threatens to destroy their old traditions and customs. It is this minority group that offers the greatest challenge to the nurse in providing adequate hospital care and in making the patient's stay as pleasant an experience as possible.

The typical Japanese family has a strong familial bond and exists as a family group. The eldest son customarily brings his bride to his

* Class of 1953, Queen's Hospital School of Nursing.

parents' home and starts his family there.[1] In the event of illness, this arrangement is less to be desired than the individual family group because of the possibility of the spread of disease due to close contact and exposure. It would be better for an outsider to come in to care for a smaller family unit, or to have the unaffected members move out in cases of serious communicable diseases.

The father is the usual head of the family and assumes responsibility for the family welfare. If the father is absent or ill, it is the traditional duty of the eldest son to shoulder this family responsibility.[1] Because of the extra burden, patients who are the heads of households may be tense and worried when confined to the hospital and more concerned about their family affairs than about their present illness. For speedier recovery, the nurse and social worker can give great help by giving the patient reassurance by constructive assistance either by financial planning or by other means of relieving anxiety caused by home conditions or other social or emotional problems.

The Japanese youngsters are taught in their religion to respect their elders.[2] Parent-children companionship is not as close as in other races, and the parent rarely shows outward affection. Many children, therefore, feel insecure and unloved and may prove to be problems in the pediatrics ward during their confinement for treatment of an illness. Affection and a sense of security are two of the basic needs of every individual, and we can understand why some children, feeling deprived of these basic needs, may develop behavior problems. An understanding nurse is tolerant toward such behavior and, in her own way, can give the child a sense of security while he is in the hospital rather than reprimand his aggressive behavior.

According to territorial law, adults are required to support their indigent parents if they are able to do so.[3] The adult children of the older generation of Japanese are expected by custom to contribute to the support of their parents. This may add to the anxiety of the patient while he is in the hospital.

The Japanese are polite and modest. They take great pride in their own family group. They bring up their children rigidly, to conduct themselves as befits their ancestors and their heritage. They are acutely conscious of social opinion and their conduct is greatly influenced by it. It is not unusual to hear of cases where parents were psychoneurotic or on the verge of a breakdown because one member of the family contracted tuberculosis, or was institutionalized for mental illness. The Japanese may be more concerned about the "social disgrace" than the illness of the afflicted relative. The nurse can enlighten the family and reassure them by informing them that no one is immune to these diseases; no disgrace is connected with them; there is no hereditary or racial trend; and our primary concern is to help the patient to regain his health as soon as possible.

In the Orient, meat was first introduced by the westerners.[4] Prior to this, the Japanese ate fish along with rice, sweet potatoes and green vegetables. The diet of the Japanese is basically well balanced but lacks dairy products. Many of the elder generation group are not accustomed to American dishes, especially creamed and spicy foods, while still others are accustomed to eating rice at every meal. It is well for the nurse to learn the wishes of these patients as special diets may be obtained for them in the hospital. An adequate, well-balanced diet is essential in the restoration of the health of these patients, and they may be unable to eat the usual hospital dishes.

In the Japanese culture men are generally considered superior to women. They are often given better opportunities in life and treated with far greater respect. As a result, many women patients are afraid to voice their symptoms and the nurse has to give them special consideration and reassurance.

The Japanese revere old age, and courtesy is shown to elders on all occasions. The thought of sending the aged to an institution is usually inconceivable to them. At times, however, this is the best solution and the nurse can help the family see that the patient will be better cared for at the Home. Aged Japanese, without families, may find refuge at the Kuakini Home or the Maluhia Home.

The older generation Japanese have definite religious convictions, and most of them belong to one of the Buddhist sects. Shrines are often found in a typical Buddhist home, where ancestral worship is practiced.[4] Many Buddhists still seek spiritual aid from their priests in the event of illness before consulting a physician. Many, however, eventually show great respect for medical science and allow doctors to take full control of the situation. With the ever-increasing incidence of diagnosed cancerous conditions, it is important for patients with symptoms to be en-

[1] Yoshizawa, E.: *A Japanese Family in Rural Hawaii, Social Process in Hawaii*—Sociology Club, University of Hawaii, Vol. 2, May 1937, pp. 56-63.

[2] Yamamoto, M.: *Cultural Conflicts and Accommodations of the First and Second Generation Japanese—Social Process in Hawaii*—Sociology Club, University of Hawaii, Vol. 4, May 1948, pp. 40-48.

[3] Revised Laws of Hawaii, 1945, Section 12290 and Section 2501.

[4] Catton, M.: *The Ethnic Groups in Hawaii—The Japanese.*

couraged to seek medical aid as soon as possible. The public health nurse can use her resourcefulness in such counselling as she makes her daily home visits.

Patients are often admitted wearing a piece of paper with some writing about their necks. This is known as an "omamori" and is comparable to a medal worn by the Catholics.[4, 2] Nurses caring for these patients should treat these articles with respect for they are sacred to the patients. The nurse should be acquainted with the various religious organizations so she may be of help when a request for any particular priest is made. According to the law, no person is allowed to practice medicine or surgery without a license. Christian scientists, kahunas, and others may, however, practice religious tenets of their church without possessing knowledge of medicine or surgery, and they are not prohibited from treating in emergencies, or from administering domestic remedies.[1]

Birth control is a taboo subject in a Japanese home and many regard it as immoral.[4] The old-time Japanese believe in large families, for they feel their children will care for them in old age. The second generation, however, are not as prolific, and accept American cultural patterns, with a strong desire for better standards of living. The nurse should assume a non-critical attitude in this matter, but if questions are asked, she should advise them to see a reputable doctor for discussion of this subject.

Sex is seldom discussed as such in the Japanese home, and thus the children gain their knowledge of sex outside of the home, at school, and from their friends. Because of this, many patients are hesitant and even embarrassed at questions referring to the generative organs. In educating gynecology patients in regard to healthful living, the nurse must use extreme tact to avoid embarrassment and rejection on the part of the patient. If a nurse assumes a professional attitude and shows genuine interest in the patients, she will be able to establish rapport with her patients and this will make discussion easier.

As a Japanese family is perpetuated through the male line only, first-born sons are desired. It is still a great event when the first born is a son. The numbers 3-5-7 are significant in the Japanese culture and on the third and fifth month of pregnancy, expectant mothers go to the shrine and pray for protection of the baby. The baby is named on the seventh day post-partum.[4] Parents are oftentimes greatly disappointed if a first born is a daughter instead of the desired son. Reassurance may be needed by the mother while she is in the hospital.

Illegitimacy is considered a disgrace.[1] Unmarried mothers are under great emotional tension because of the rejection by the family. The feelings of the Japanese family vary; some grandparents may wish to bring the baby up, while others reject the baby. Undue pressure may be brought on the patient to marry to "make her decent" again. The patients are apt to be depressed and require social service counselling while in the hospital. The nurse should try to create a cheerful, quiet atmosphere, where mental as well as physical rest can be obtained.

Deformities are considered a disgrace by the Japanese for they believe it reflects on their heritage.[4] Deformed children are often kept in seclusion and are cared for by the family. These children may lack a sense of security because of resentment toward them on the part of the family group. Parents can be told that physical handicaps may best be corrected if treatments are instituted early. Feeble-minded children may be cared for at the Waimano Home, and in most instances, the child will feel happier there than at home. The family should be assured that these disabilities are no reflection on the family itself.

Since marriage is one of the most important events of life, Japanese parents often expect to pick the bride for their sons, and it is looked upon as a family affair.[1] They believe that the welfare of the family in future years will come about with successful marriages of the eldest sons. Interracial or even interclan marriage is frowned upon for fear of jeopardizing the social status of the family. Many young people who have intermarried are rejected by their parents and their friends. When this occurs, patients need extra attention from the doctors and nurses. At times the nurse can help in a reconciliation.

The older Japanese cling to ancient customs and manners of speech. They are often disturbed when members of the younger generation are unable to express themselves adequately, and the older people therefore consider them rude and disrespectful. A nurse should establish rapport with these patients by being aware of their language difficulty and in being courteous and thoughtful of the patient.

In making this study of Japanese culture, I have gained a great deal of insight into Japanese customs and traditions. I feel that I can give better nursing care to these patients than I could previously because of my new understanding and knowledge of their beliefs and actions.

## ACTIONS OF YOUR BOARD OF DIRECTORS

March 13, 1953

*Heard* Territorial committee reports:
Legislative, Membership, INTER-ISLAND BULLETIN, Economic Security, Program.

*Accepted* the following recommendations from the Economic Security Committee:

1. That the publication "Economic Security for Nurses Fact Sheet" be distributed to the membership.
2. That an orientation course covering functions of sections and economic security be given section representatives who are attending the ANA workshop for sections to be held in San Francisco in May.
3. That NATH Board suggest to the Territorial sections that the officers prepare a ballot with names of members who could attend the ANA workshop and then send this ballot to the section membership for vote.

*Moved* that the registration fee for the annual convention be $1.00; that the press be invited to all program meetings; other information to be cleared through the Nursing Information Committee; that practical nurses be invited to attend the program meetings and be charged no registration fee; that students be invited to attend all meetings, paying a registration fee of twenty-five cents.

*Suggested* consideration of a program on disaster preparedness at the annual convention.

*Accepted* definite dates of the annual convention as August 28, 29, 30.

*Heard* Territorial Section reports:

**Private Duty:** Three committee chairmen have been appointed. Standards for practice have been studied and set up and are ready for adoption. Revised rules were presented to the Board and were approved. Ready for distribution to the membership.

**General Duty:** Committee chairmen have been appointed. Rules are being considered. A district general duty section has been formed on Oahu.

**Public Health:** Two committee chairmen have been appointed. Rules were discussed at the organizational meeting but have not been completed. Suggested that the program for the annual convention be deferred until after San Francisco workshop.

**Institutional Nursing Service Administrators:** All committees have been appointed. Rules were accepted by the Board and are ready for distribution to the membership. Suggested a program on interpersonal relationship for the annual convention.

**Educational Administrators, Consultants and Teachers:** Committee chairmen have been appointed. Rules have been discussed but are still in committee.

**Industrial:** Chairman absent. (Industrial seminars on Oahu and Maui were well attended. Numerous recommendations were made which should be followed up by the section.)

*Signed* Agreement for Standard Service from ANA Counseling and Placement Service. This is an agreement that the Territory will conduct the Counseling and Placement Service according to the standards as set up by ANA, in return for which ANA supplies forms, advice and coordinating services.

*Heard* report that the practical nurses are planning the formation of a Territorial Association.

*Discussed* coverage of NATH Workmen's Compensation.

*Discussed* possibility of alternates for members of the Board of Directors. Moved that if necessary alternates may be sent for the next Board meeting; expenses paid by NATH; but without vote. Opinion to be sought from ANA.

*Directed* the Constitution and By-Laws Committee to prepare an amendment to the by-laws providing for the inclusion of the Territorial Section Chairmen as members of the Board. This to be considered by the Districts and voted upon at the annual convention. ANA section chairmen are members of the ANA Board of Directors.

*Discussed* possibility of inviting District presidents to attend Board meeting. Directed Executive Secretary to highlight Board minutes for District presidents.

*Directed* the Secretary to write a letter to Governor King requesting reappointment of Dr. Wilbar.

*Moved* that Mrs. Page, office secretary, be granted an increment ($7.50) upon her anniversary date.

*Heard* brief report on the January ANA Advisory Council meeting from Mrs. McCall.

*Directed* the Secretary to write to Governor King and recommend the reappointment of Mrs. McCall to the Board for the Licensing of Nurses. She filled an unexpired term which now expires in April.

*Agreed* the transportation expenses of the section representatives to the ANA workshop should be paid by NATH until recompensed by ANA.

Next meeting to be held June 12.

*The Mabel L. Smyth Memorial Building was dedicated in January of 1941. Since that time a new generation of nurses and doctors has grown up in Hawaii. To tell them the story of the growth of the idea and the building and to do honor to those who worked so hard for its realization, we present:*

## THE STORY OF THE MABEL SMYTH MEMORIAL BUILDING

*From the minutes of the Board of Trustees, Nurses' Association, Territory of Hawaii, March 10, 1936.* Considerable discussion followed concerning the Nursing Service Bureau. Miss Matthews reported on a meeting with Dr. Bell who suggested that the Nursing Service Bureau have space adjoining the medical library at Queen's Hospital and that they join in paying a full time clerk librarian who could take care of the Bureau's clerical matters. At present the library has a part-time librarian and is not available to doctors at all times as they desire. A tie-up with the Nursing Service Bureau might make a more satisfactory arrangement for both parties. Dr. Bell also said that the doctors might be interested in a registry which could be connected with the Nursing Service Bureau which would be a source of income. Miss Matthews spoke of the objections and advantages of such a plan. Mrs. Bohr pointed out the value of the original suggestion coming from the medical profession. Mrs. Akana suggested that the Nursing Service Bureau submit an annual budget so that the needs of the Bureau would be definitely known. It was felt that this might be a satisfactory beginning to combine with the doctors, also that it might become a central registry for dentists, Territorial Nurses' Registration Board and City and County Nurses' Association. It was also suggested that the Chamber of Commerce and the HSPA might assist in this venture, but that the nurses should be unanimously back of such a move before outside aid was requested.[1]

[1] *Committee to Study Amalgamation of Nurses and Doctors Facilities:* Drs. Bell, Black, Molyneux, Halford, Schattenburg, Phillips; Misses Rieckman, MacOwan, Schleif.

**Mabel Smyth died suddenly following surgery March 26, 1936.**

*Minutes of the Board of Governors, Honolulu County Medical Society, April 3, 1936.* Dr. Bell stated that the nurses at their March meeting had decided to make some changes in their Nursing Service Bureau and at this time suggested to plan to combine the Nursing Service Bureau and the Medical Library. Mrs. Akana announced a plan for combining at least four agencies: The Physicians' Library, a Physicians' Exchange, a Nurses' Registry and the Nursing Service Bureau. This plan would call for the services of three nurses and one clerk. Dr. Arnold, Sr. stated that this had been discussed before and had been found very practical and agreeable. Dr. Bell stated the time will come when the library quarters will have to be given up. He has talked with Mr. Potter about the possibility of the trustees giving a piece of land for the erection of a building to house such an organization and Mr. Potter felt the trustees might acquiesce. Mrs. Akana felt if the land could be acquired a plan could immediately be started for the erection of such a building as a Mabel L. Smyth Memorial Building. She has discussed this with others who likewise felt that donations would be forthcoming. Dr. Phillips asked if there was any definite idea as to the length of time the present quarters would be available. Miss Rieckman felt if the hospital continues to be as busy and full as recently, the space will soon be needed. Dr. Phillips felt if the efficiency of this unification of service could be demonstrated, the plan for the erection of a building could be undertaken. Mrs. Akana suggested that such a large body was too unwieldy for discussion and that a meeting between a committee of the Nurses' Association and the Medical Society be arranged. Dr. Molyneux moved that the chairman appoint such a committee to report back to the Board of Governors at the next meeting.[2]

[2] *Committee of Doctors and Nurses, April 3, 1936:* Drs. Bell, Doolittle, Molyneux, Schattenburg, Kuninobu, Black, Trexler, Phillips, Reppun; Misses Reickman, Matthews, MacOwan, George, Alice Kim; Mesdames Akana, Shaw.

*From the minutes of the annual meeting, Honolulu County Medical Society, April 3, 1936.* Address of the president, Dr. Bell. There is a brewing plan to enjoin the Nursing Service Bureau and the Medical Library. Our quarters on the third floor of the Liholiho wing may at any time be jeopardized by the increasing need of The Queen's Hospital for more space. By combining with the nurses we may be able to work out some scheme that would give longer library hours and also return monies to the treasury for operation. A doctors' telephone exchange and employment bureau, to mention two possibilities, might be incorporated in such a plan. Seeing the eventual need of moving, I have sounded out hospital authorities to see if we might be given a grant of land on the hospital grounds for use as a library. They are attentive and willing. A building constructed on these grounds to house the library,

an auditorium and business office of the Society, it seems to me, is a growing necessity. I believe that a workable plan can be found and such a building erected if all are willing to work, for such a building should be our constant objective.

*Minutes of the Board of Trustees, Nurses' Association, Territory of Hawaii, April 14, 1936.* Mrs. Akana presented the plan for the amalgamation of the Nursing Service Bureau and other agencies. The concensus of opinion was that it was a good move and Dr. Bell was instructed to report to the Honolulu County Medical Society that favorable action be taken and that a committee be appointed from the medical group to work with the nursing group. Dr. Bell reported that Dr. Withington, a member of The Queen's Hospital Board of Trustees, feels confident that a piece of hospital property would be made available to the doctors and nurses for the purpose of constructing a building thereon. Mrs. Bohr moved, seconded by Miss Williams, that a committee be appointed to collect money for the Mabel L. Smyth Memorial Fund and that legal advice be obtained as to the necessary procedure, all monies to be accepted in the name of the association. Miss Laura Hooker was appointed chairman of this committee.

*From the minutes of the special committee, Mabel L. Smyth Memorial Fund, May 13, 1936.* Present were Miss Laura Hooker, Mrs. Elsa K. Chillingworth, and Mrs. Thelma Akana. It was decided that two more members should be added to the Committee from Honolulu and Mrs. Joseph French and Miss Elizabeth McKay were suggested. The president read a letter which was presented to Mr. John Hamilton, Secretary of the Chamber of Commerce, regarding this subject as follows: "As a memorial to the late Mabel L. Smyth, the Territorial Nurses' Association is planning the erection of a building, funds for which will be raised in the following manner: Subscription from the members of the Medical Society and Territorial Nurses' Association; donations from various individuals who were friends of Miss Smyth ($5,000 from one individual has already been promised); soliciting support from various estates and groups. This building will be known as the Mabel L. Smyth Building, will consist of an assembly room for doctors and nurses meetings, as well as offices for the Medical Library, the Nursing Service Bureau, a Physicians' Exchange, and the Board of Nursing Registration. Cost will be in the neighborhood of $75,000 and will be maintained by the Territorial Nurses' Association and the City and County Medical Society. This move has been endorsed by the Medical Society and we would appreciate having the endorsement of the Chamber of Commerce." Miss Sinclair moved, seconded by Mrs. Bohr, that Mrs. Akana be empowered to ask the Board of Trustees of Queen's Hospital what piece of land they have to offer for such a building, the size and location, and what stipulation there may be as to the erection of said building.[3]

[3] *Site Committee, May 1936:* Albertine Sinclair, Stella Matthews, Elsa K. Chillingworth.

*From the minutes of the Board of Governors, Honolulu County Medical Society, May 13, 1936.* The merger of the Nursing Service Bureau and Physicians' Library is postponed until October for the following reasons: (a) It is necessary to have more time to arrange details. (b) The new telephone directory will not be out until then. (c) By that time it will probably be necessary to move the present library quarters and it seems improper to attempt to furnish new quarters for the Nursing Service Bureau on Liho III. It seems quite probable by that time that the Mabel Smyth Memorial Building will be under way. The plan for this building program is being accepted with great enthusiasm on all hands. Mr. Dickey, the architect, was enthused about the idea and Mr. Ray Morris has agreed to draw up some plans as an illustration without any strings attached. Mrs. Akana reports $5,000 of which $1,000 is in cash contributed by one individual in the community. Various members of the Board of Trustees of the hospital have been consulted and their reaction has been favorable, but a plan has not been officially presented to this organization. Motion: It was moved and seconded that the Board of Governors favor the program of collection of funds for a Mabel Smyth Memorial Building to be housed on The Queen's Hospital grounds to provide quarters for the Physicians' Library, Physicians' Exchange, Nurses' Registry and the Nursing Service Bureau. This was passed unanimously. It was moved and seconded that the president appoint a senior member of the Society to act with Mrs. Akana to raise funds for this memorial among the physicians. Unanimously passed.

*From the minutes of the Board of Governors, Honolulu County Medical Society.* Drs. Judd and Larsen were appointed to serve on the committee with Mrs. Akana and the following doctors: Bell, Chung, Molyneux and Duryea, to aid in furthering the merger.

*From the minutes of the Board of Trustees, Nurses' Association, Territory of Hawaii, June 5, 1936.* A good part of the meeting was taken up in the discussion of the proposed plan of amalga-

mation of nursing activities and a memorial to Mabel L. Smyth. There was also discussion as to the advisability of looking around for a site other than The Queen's Hospital for the proposed memorial building, and it was felt by some members that this matter should be investigated before the site offered by The Queen's Hospital is accepted. A personal tour of sites available at Queen's Hospital was made by the Trustees, but no decision reached. Miss Matthews moved, seconded by Mrs. Bohr, that a committee of two doctors and two nurses as well as the president of the Territorial Nurses' Association be appointed to investigate other sites. Motion carried. A mimeographed letter regarding both the amalgamation and the proposed memorial to Mabel L. Smyth will be sent to each member of the Territorial Nurses' Association for her information and comment.[4]

[4] *Committee for Soliciting Funds, June 1936:*
*Oahu:* Laura Hooker, Chairman; Mrs. Chillingworth, Mrs. Akana, Bess Young; Drs. Hodgins, Withington, Arnold, Judd, Phillips, Doolittle, Larsen.
*Hawaii:* Mary Stanley, Chairman; Jane Service, Clifford Bowman, George Lowson, Mrs. Albert Ruddle, Caroline Shipman; Drs. Walter Seymour, Clyde Phillips.
*Maui:* Marian MacMillan, Chairman; Mrs. Charles Ashdown, Elizabeth Marks, Marion King, Corrine Jackson, Mrs. Howard Powers, Mrs. Annie Chalmers.
*Kauai:* Theo Floyd, Chairman; Mabel Wilcox, Mrs. Helen Layton, Mrs. Carra, Miss Wall, Mabel Coleman, Mrs. Lakory, Miss Gane.
*Molokai:* Gwendolyn Shaw, Chairman; Alice Young, Louella Tanner.
*Lanai:* Jean Fraser.
*U.S.P.H.S.:* Dr. Ira Hiscock.

*From the minutes of the Nurses' Association, Territory of Hawaii, April 13, 1936.* Discussion followed concerning the showing of the Florence Nightingale picture entitled "The White Angel" as to whether or not proceeds from a benefit performance should be used towards the Mabel L. Smyth Foundation. The secretary was requested to write to the American Nurses' Association for information on this matter.

*From the minutes of the Nurses' Association, Territory of Hawaii, Board of Trustees, August 13, 1936.* Miss Sinclair reported on a meeting of the site committee. There were two sites considered—one off The Queen's Hospital grounds at the corner of Punchbowl and Miller Streets which could be purchased at $1.10 a square foot, and the other at Kinau and Alapai Streets. This latter, however, was considered too far away from the hospital to be advisable, and the first site too expensive, the price ranging around $30,000. A second meeting of the site committee was held with Dr. MacEachern, of the Hospital Association, during his recent visit and the site between the nurses' home and the hospital considered the best available place. Miss Sinclair also reported on a meeting with Dr. MacEachern at which the following points were brought out: (1) Possibility of doctors withdrawing their support if the building were elsewhere than Queen's Hospital grounds and (2) That Queen's Hospital would be the proper and convenient location for a medical center if one were built in future years. In the future when Miss Smyth's name might not mean so much to people, the building would still be used and would harmonize with its surroundings.

To be continued

## PIONEERING ON MAJURO

MRS. MARY LEW, R.N.

Mrs. Mary Lew has recently gone to the Trust Territory to work and we thought you would be interested in the following letter received by Miss Blanche Gay:

"It was January 28 before I arrived in Majuro and I wanted some impressions to jell before sending out messages. Actual flight time was about thirty hours. I was sent into other districts to study community and hospital conditions.

"After leaving Guam we traveled by United Nations planes that seat only ten people. Every detail of travel is well arranged. There is good food and friendship along the way. Government jeeps and a delegation meet all planes. They take care of baggage and when you transfer they call for you. One night I spent alone in a spooky house, but the bed was clean.

"The houses in Majuro are the queerest Navy remnants on the outside; designed to keep rain and heat out. They all need paint, however nice inside when fixed up. There are modern plumbing, electricity, ice boxes and electric stoves. Furniture is a mixture of old pieces and luxury bamboo sets from the Philippines.

"The ten quonset huts of the hospital are not bad looking on the outside. The first few days I spent throwing out old cartons, broken bottles and rubbish. There was not an extra sheet to change beds, no cake soap. The sterilizing equipment in surgery was out of order. We average about two hospital deliveries a week. I do not have to make house calls; we have heard of every method of doctor's travel, here they go by bicycle. Patient care is given by nurses whose level is about our practical nurse group. Then there are young boys who are health aide trainees. They are a big help, but can learn a lot about our standard of a clean hospital. Our patient census averages 20; tuberculosis, orthopedic cases, and mothers mostly, a few children. The nurses are pleasant and willing. The patients do not complain too much, I would say are easily satisfied.

"Then the flu epidemic hit the community. I set up an eight-bed isolation ward in an hour. I was surprised how fast the boy health aides could move when there was a project to be done. They used mattress covers for sheets. I got empty ginger ale bottles for fluids as

there are no pitchers. One week end I made sheets from a bolt of unbleached cotton. The school did the stitching. Anything that I say is not complaint; it is to give a true picture of the needs to be met. There are medical supplies but the wrong kind, as laboratory supplies that will not be used for ages.

"I have not minded the isolation, it is surprising how much activity there is. There is a library of a sort, movies, old films, two times a week. I never cared for the movies. Visiting experts who lecture.

"One Sunday, hospital personnel had use of a launch. We went to an uninhabited island for a picnic, the usual hot dog, beans, bread and rice, cold drinks. The boys cut down coconut palm leaves for a picnic cloth, made us each a tray by braiding coconut leaves just enough to hold together. There is not much in local food except bananas and coconuts.

"You sit on the shore and think how awful to get stranded, no boat would ever rescue you, it is so isolated.

"It is not so quiet here, the wind is usually blowing, the ocean is beating on the shore. In the still of the night, a coconut drops on the roof or a frond makes a thud. Even if no passenger luxury cars, the service trucks or jeeps are bouncing around. The heat is not too intense just now.

"The United Nations mission will be visiting here next week. Plane day is once a week when we get mail. The United Nations emblem flies every day with our national flag.

"There is one American doctor in charge. I am glad he likes it here. Also, three native practitioners who have studied in Guam.

"I have not regretted taking the chance on this pioneering project. It is worth it in service to our country and humanity.

"I wonder if you will get me two dozen nursing bottle nipples for the narrow mouth Pyrex bottle. Please send by air mail; we cannot get them in a store here.

"We do have magazines. However, if a later project, you or any club would like to work up. Any pieces of cloth, no matter if unwanted colors or patterns in Honolulu, from one yard or more to make clothing. White, even the unbleached kind, for the hospital. This can be sent slow mail, if it is directed:

Mrs. Mary Lew, R.N.
Fort Ruger, 3845 Kilauea Avenue
Public Health Dept., Honolulu
Please forward

The packages will be forwarded to me at government expense. Thank you for what you can do.

"My things have not arrived, I am still living from the suit-cases. I have sent an order to Sears; it will be a long time before I get it."

## NEWS FROM THE NURSES' ASSOCIATION, COUNTY OF KAUAI

Recently elected officers of the Nurses' Association, County of Kauai are: President, Miss Myrna Campbell; First Vice President, Mrs. Pauline Johnson; Second Vice President, Mrs. Grace Furugen; Secretary, Miss Martha Hiramoto; Treasurer, Mrs. Marion Kawate; Board of Directors, Miss E. H. Middleton, Miss Thelma Hensley, Mrs. Clella Cockett and Miss Lillian Chong.

On February 14 Miss Alice Iwamoto and Daniel Togikawa were united in marriage at the Kapaa All Saints' Church.

Miss Thelma Hensley of Mahelona Hospital left on January 29 for a three months' trip to Mexico.

Miss Edith Yamagata and Mrs. Tsugie Kadota, both of Wilcox Hospital, were honored at a farewell luncheon in February, the former leaving for post-graduate work in operating room at Johns Hopkins and the latter taking maternity leave.

New arrivals at Wilcox Memorial Hospital include Miss Emiliana Daniel, Miss Rosalia Dela Cruz, and Miss Ida Oganeko, St. Francis graduates, and Miss Mary Ellen Diggory and Miss Julia Hlady, graduates of Galt Hospital, Lethbridge, Alberta, Canada.

## SCHOLARSHIPS

The Commission on Nursing Education and Nursing Service has just completed a mimeographed pamphlet that gives condensed information on scholarships available for nurses. A folder with additional information has been sent to the president of each district association, with the request that it be placed in a convenient place and all nurses on the island be informed of its location.

Many excellent and generous scholarships are listed.

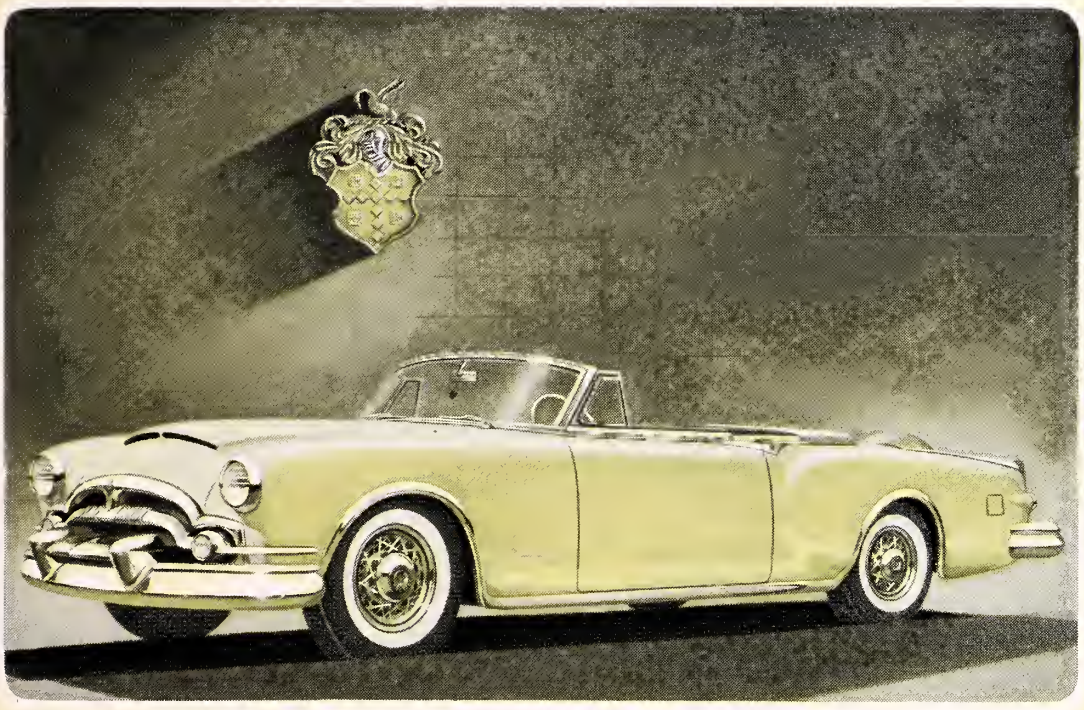
It is hoped that enough interest will be stimulated to encourage several island nurses to take advantage of this opportunity. We need better prepared nurses along several special lines.

Consult your district association president or Miss Leona Adam, our executive secretary. She has additional information at Mabel Smyth. She is also available for counseling if you are in doubt as to choice of school or preparation.

## GROUP PROFESSIONAL LIABILITY INSURANCE AVAILABLE THROUGH A.N.A.

The subject of professional liability insurance is one of vital and immediate importance to the nursing profession. The annually increasing number of claims and lawsuits for alleged carelessness and negligence should be a warning that its professional reputation and earnings are in jeopardy.

The maxim "An ounce of prevention is worth a pound of cure" is of special significance to the nursing profession. It is the hope of your association that the program that has been instituted will be preventive as well as remedial, through the release of educational material from time to time, which should reduce the causes of accidents and damage suits. The program will, of course,



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be remedial in providing insurance protection to members of the association when claims arise.

A master insurance policy has been issued to the American Nurses' Association under which each individual member of the association becomes eligible for the new insurance protection. The minimum limit is 5/15 thousand dollars, which means that you will be insured up to $5,000 for any one claim under each certificate, and up to $15,000 for each annual period. Higher limits of protection are available at slightly increased cost. Except for the states of Louisiana, Texas, and New York, you may purchase this protection for a period of three years at a saving of one-half a year's premium.

This program is underwritten by the St. Paul-Mercury Indemnity Company, a member of the St. Paul Group of companies which has been in business since 1853. It has 10,000 representatives scattered throughout all the states in the union, and through this medium can serve all your insurance needs. The St. Paul-Mercury has had long experience in handling professional liability programs for associations in fields allied to the nursing profession.

Under this plan there will be no individual solicitation. However, the American Nurses' Association feels proud that it has been able to arrange a national program of insurance protection for its members, and heartily recommends its acceptance.

If you desire to participate, write directly to ANA National Headquarters, 2 Park Avenue, New York 16, N. Y., for an application form. When this form has been filled out properly and returned, the American Nurses' Association will arrange to have your insurance become effective on the date your certificate is issued.

## BOOK REVIEWS

### *Nutrition and Diet Therapy in Relation to Nursing*

By Marie V. Krause, B.S., M.S., 562 pp., Price $4.25, W. B. Saunders Company, Philadelphia, 1952.

Nurses, do you need an up-to-date reference book on nutrition? You will find this text complete, practical, easy to understand and easy to read with the exception of the food tables in the appendix which are in too fine print for extensive reference work.

The organization is very good; the division into four parts enables a comprehensive consideration of each. Topics discussed are normal nutrition, metabolism, applied nutrition, and nutrition in pregnancy, lactation, infancy, and childhood. Diet therapy, nutrition in public health and factors which are important in cookery also have been included.

The relationship and the importance of diet to total nursing care is emphasized along with the recent concepts in nutrition. Due recognition has been given for meeting the physiologic and the psychologic dietary needs of the patient and the consideration of his sociologic background; these are objectives which have to be attained in each situation of comprehensive nursing care.

Nutrition instructors for student nurses will appreciate the value of the Teacher's Manual which may be purchased along with this text.

CYNTHIA L. WOLFE, R.N.

### *Laboratory Manual for Microbiology*

By Catherine Jones Witton, 76 pp., 8½ x 11, Price $2.00, McGraw-Hill Book Company, New York, 1952.

This is an excellent laboratory manual for use in teaching students of nursing the aspects of microbiology they will need to know. Practical, precise, and pertinent, it presents clearly—and always from the point of view of the student nurse—the information and the techniques that, together with her course of training, will help to make the young nurse "germ conscious" (as Miss Witton puts it in her equally excellent textbook on *Microbiology with Applications to Nursing*). The laboratory manual and text are designed to complement each other, and page references in the manual to material in the text should help to keep the student completely oriented in the course. Moreover, the manual (like the text) has an attractive and unconfusing appearance—a virtue that is not shared, unfortunately, by all laboratory manuals in the sciences.

(This review was written by a professor of microbiology at the University of Hawaii.)

CYNTHIA L. WOLFE, R.N.

### *Pharmacology and Therapeutics*

By Charles Solomon, M.D., F.A.C.P., with the collaboration of Elizabeth S. Gill, B.S., R.N., 656 pp., 6th edition, Price $4.50, J. B. Lippincott Company, Philadelphia, 1952.

Previous editions of this text have been published under the title *Pharmacology, Materia Medica, and Therapeutics;* nurses will find this new edition a good reference book. Since the author was a delegate to the United States Pharmacopeial Convention, his selection of drugs in this text are those whose usefulness have been accepted and are in close adherence to the listings in the *United States Pharmacopeia XIV, National Formulary,* and *1952 New and Non-official Remedies*. The study of many drugs has been added to this edition; among these are penicillin, streptomycin, bacitracin, Aureomycin, chloramphenicol (Chloromycetin) cortisone, ACTH, curare, and radioactive isotopes.

Consideration of each drug includes characteristics, action, effect, mode of administration, untoward effects and the use in clinical medicine. The introduction contains a variety of information on drug legislation, drug standards, official and trade names of drugs, nursing ethics and etiquette, and present day problems. A chapter on Drugs and Solutions will assist nurses who have been inactive and wish to have a refresher on metrology. A listing of the Dosage of Commonly Used Drugs will make this a good text to be added to all ward libraries.

The format has been changed and arranged in two columns of small type which does not seem to make for easy reading.

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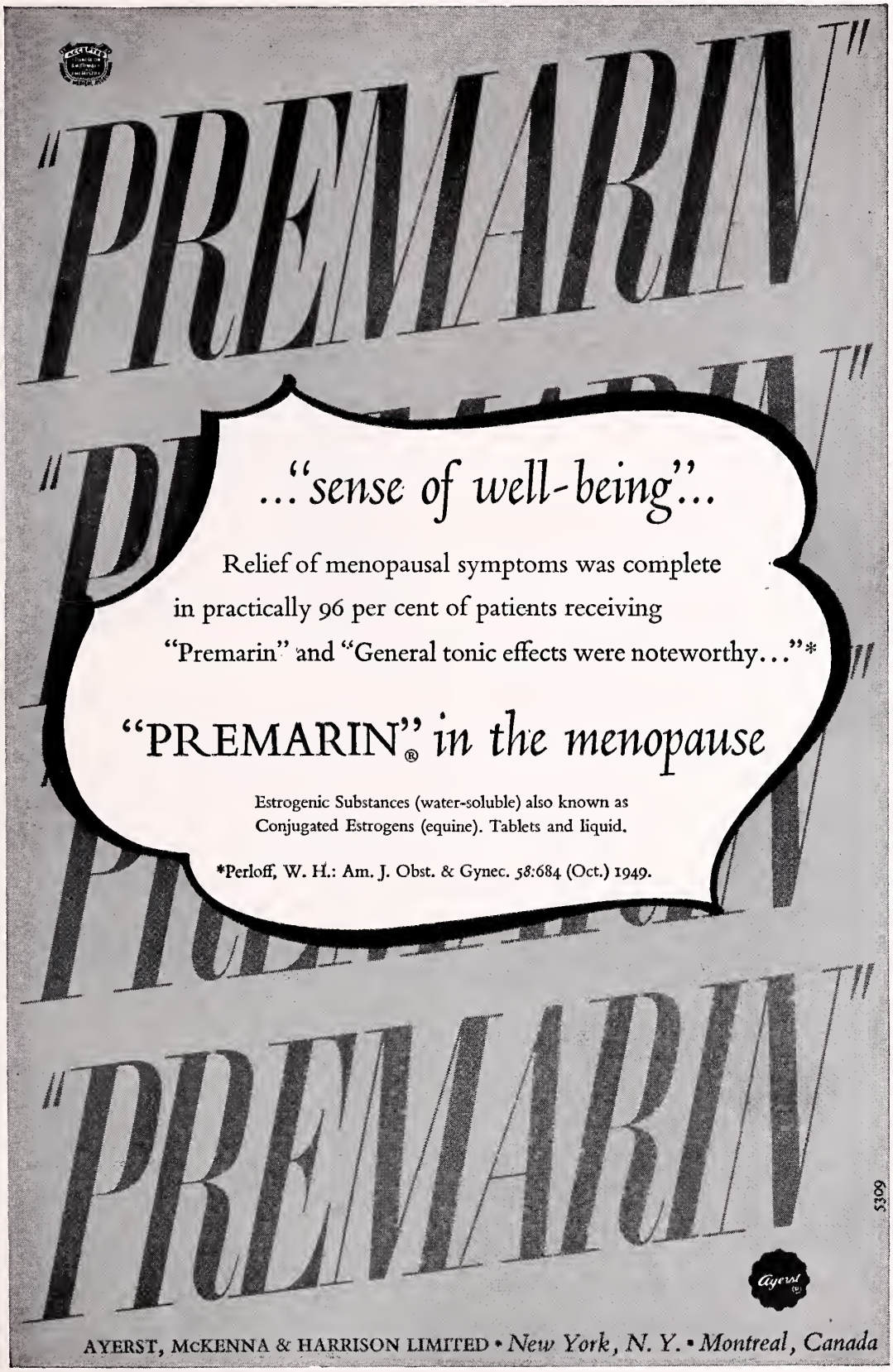
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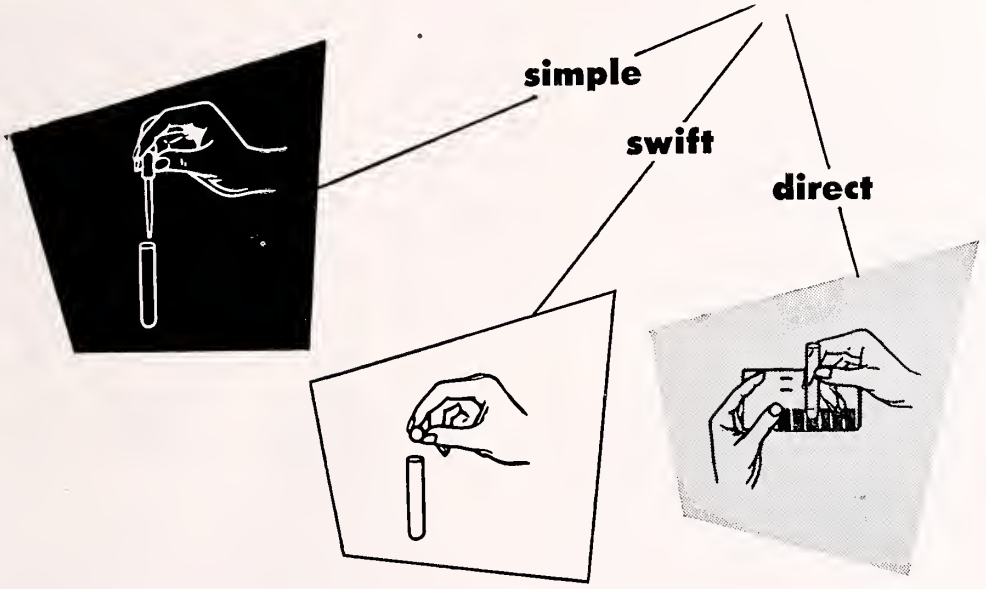
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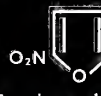
*Anderson, J. R. and Steele, C. H.: Laryngoscope 58:1279 1948. Douglass, C. C.: Laryngoscope 58:1274 1948. Long, P. H.: A-B-C's of Sulfonamide and Antibiotic Therapy, Philadelphia, W. B. Saunders, 1948, p. 152.

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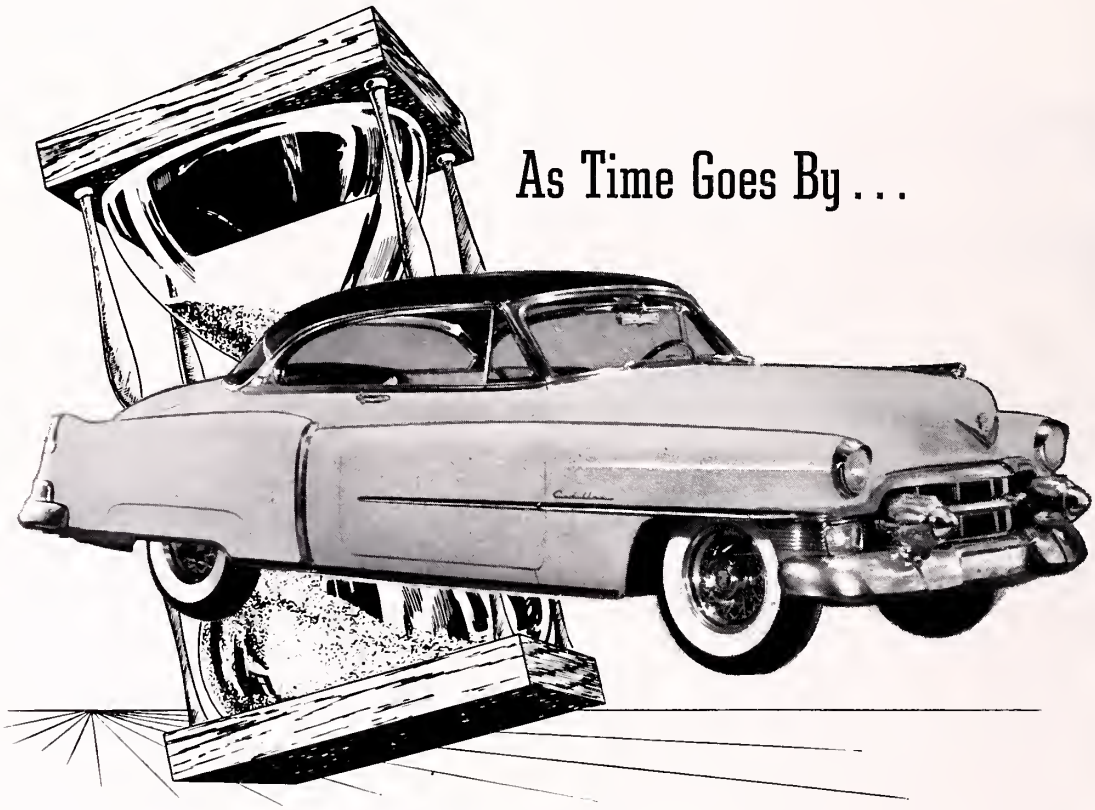
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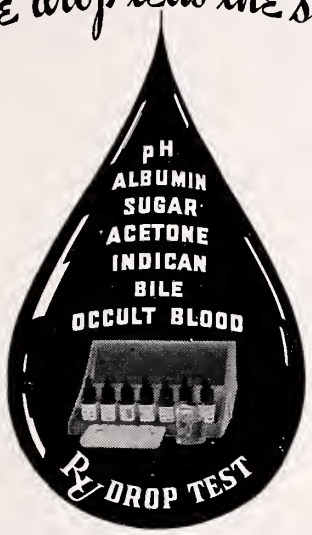
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Deucher, F.: Schweiz. med. Wchnschr. *82*:1 (Jan. 5) 1952.

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Farley, W. J., and Konieczny, L.: J. Pediat. *42*:177 (Feb

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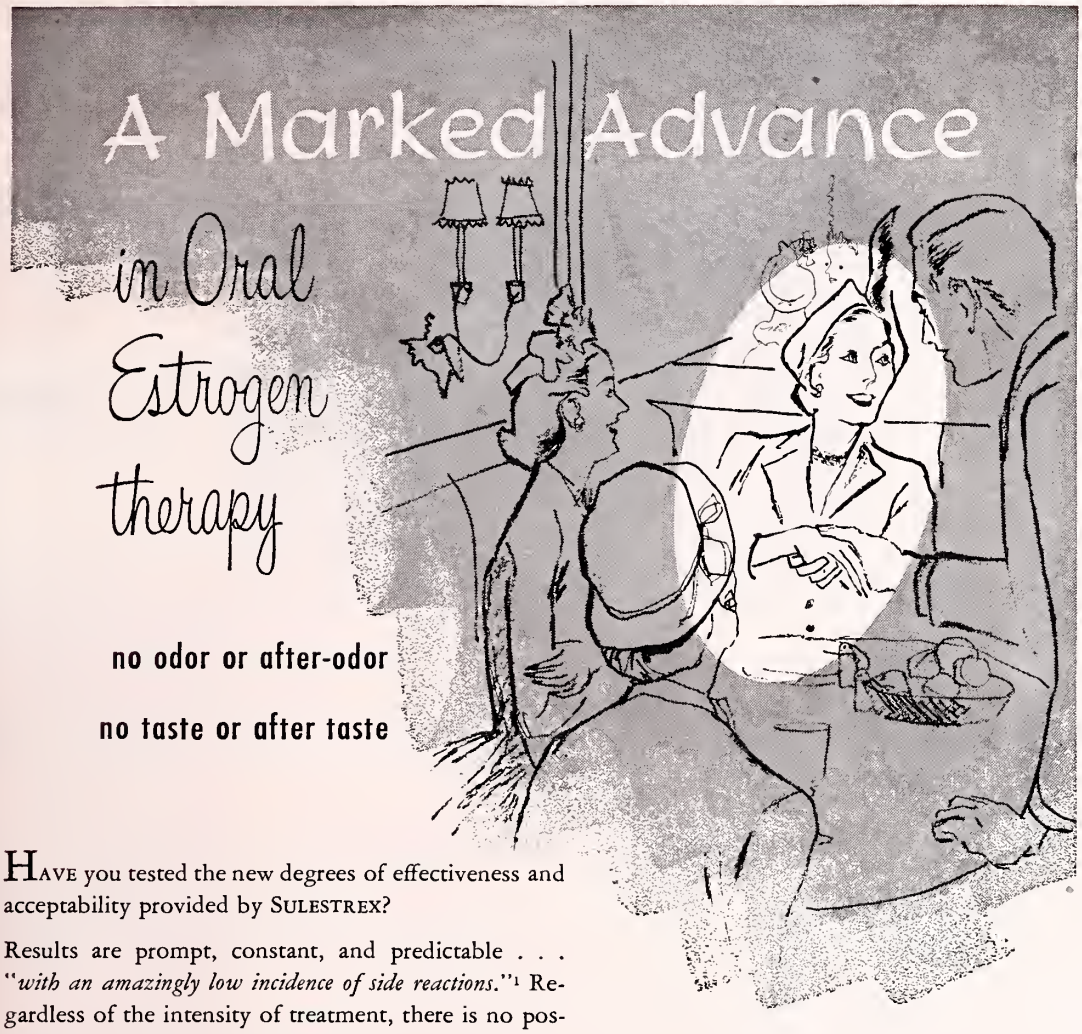
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1. Reich, W. J. et al. (1952), A Recent Advance in Estrogenic Therapy. II. Amer. J. Obst. & Gynec., 64:174, July.

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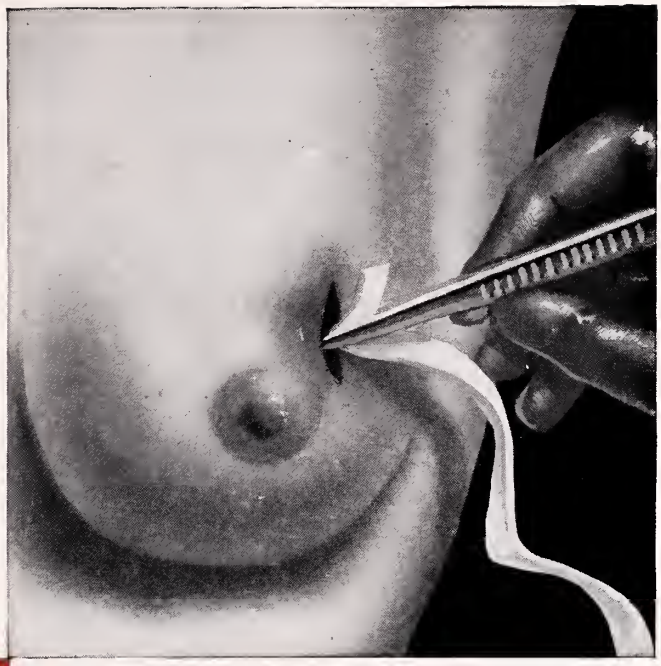
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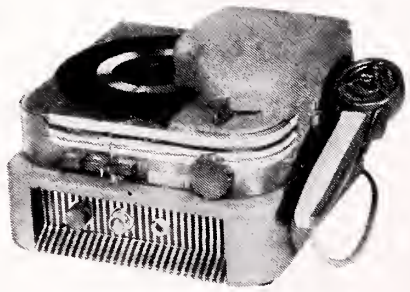
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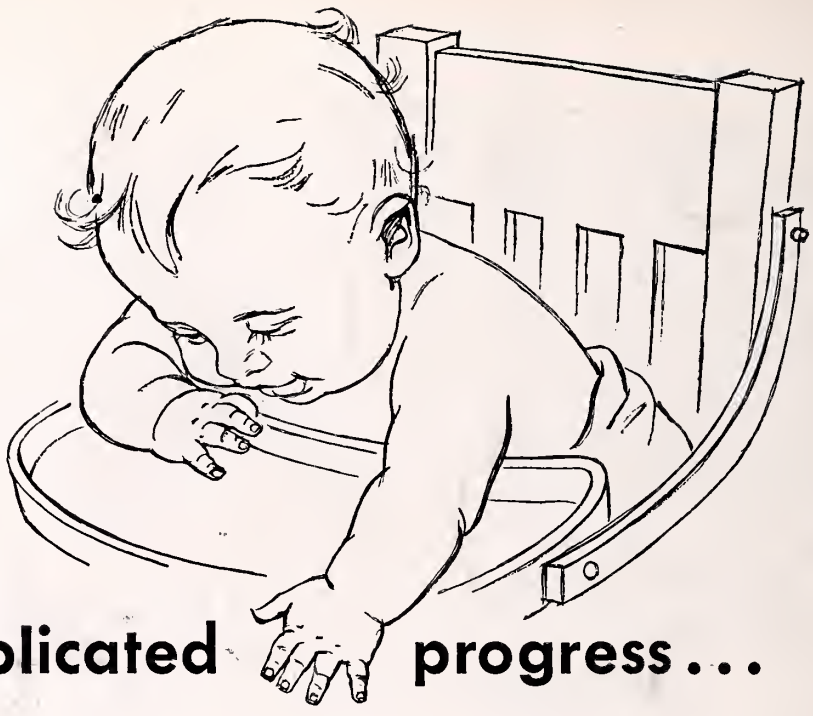
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1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592, 1951.




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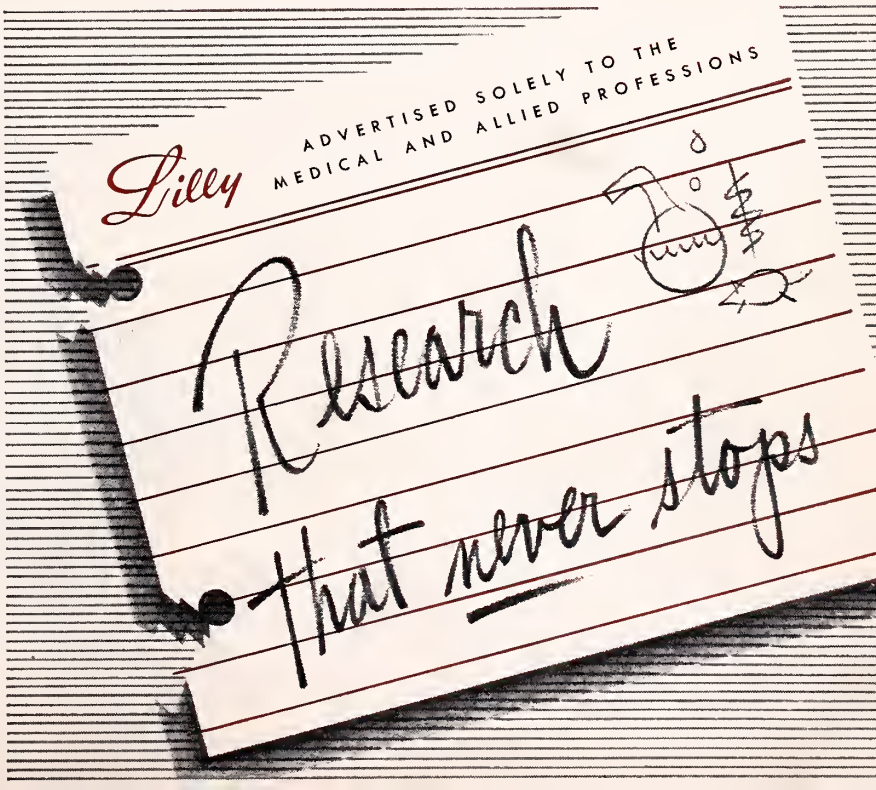
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(1) Krantz, J. C., and Carr, C. J.: The Pharmacologic Principles of Medical Practice, Baltimore, The Williams & Wilkins Company, 1949 (Reprinted 1950), p. 518. (2) *ibid*, p. 515. (3) Carter, S.: Epilepsy, in Conn, H. F.: Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 612. (4) Salter, W. T.: A Textbook of Pharmacology, Philadelphia, W. B. Saunders Company, 1952, p. 231.

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# HAWAII MEDICAL JOURNAL

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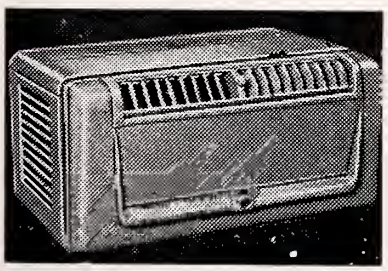

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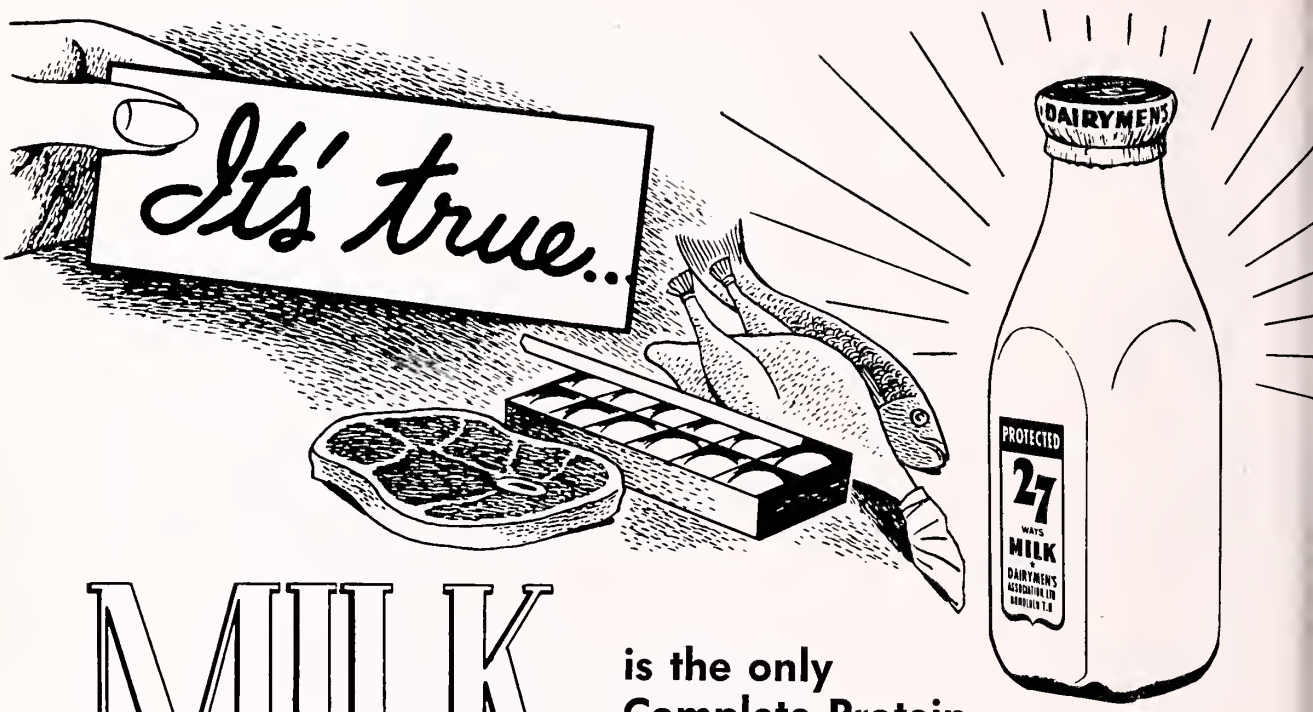


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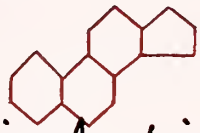
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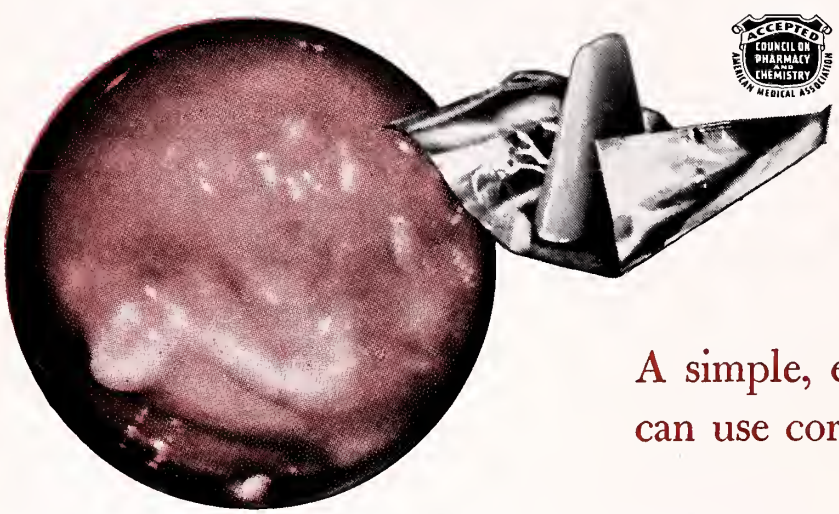
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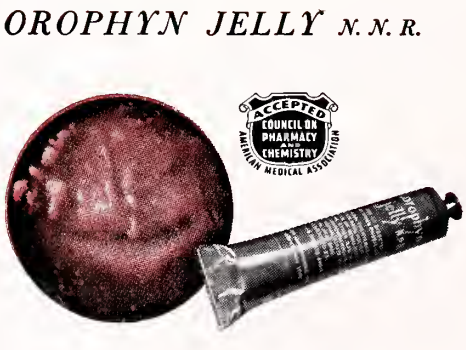
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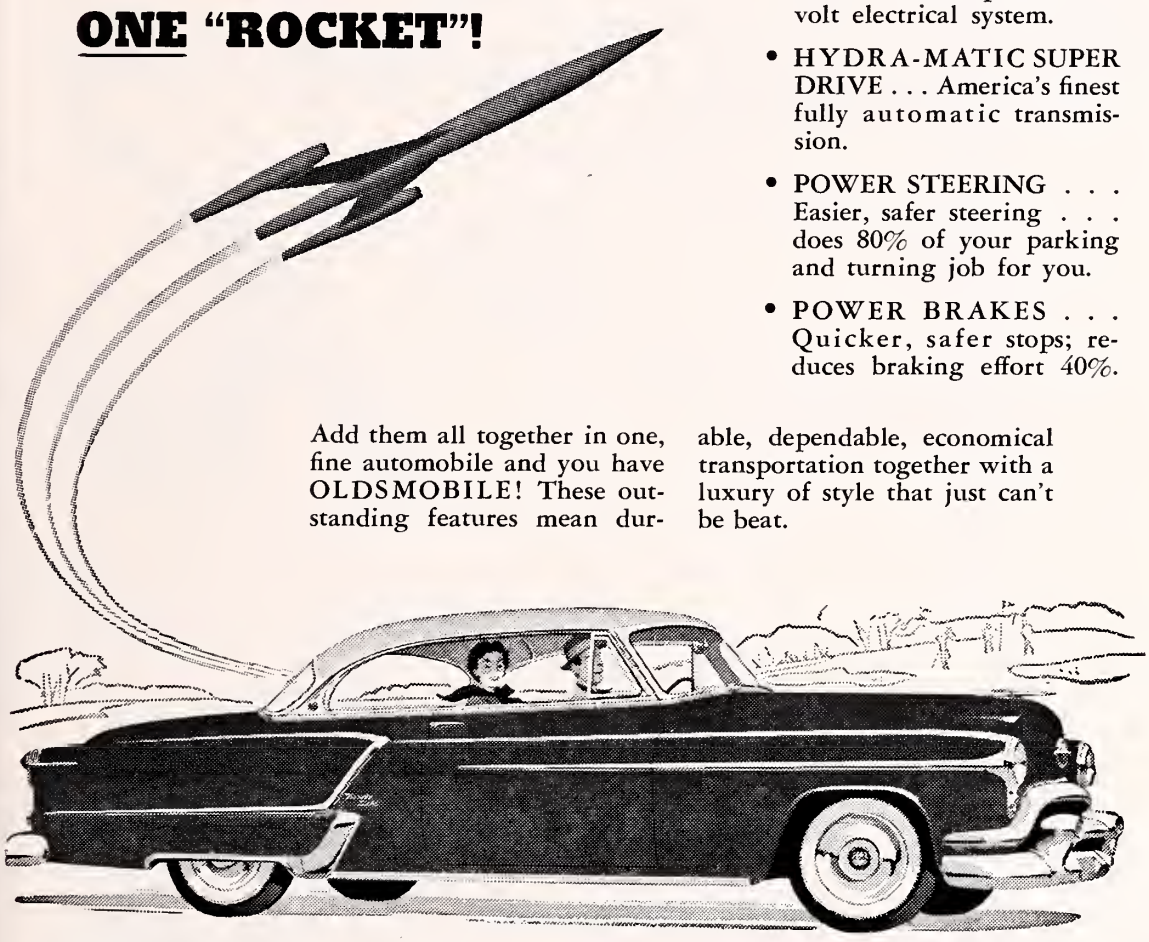
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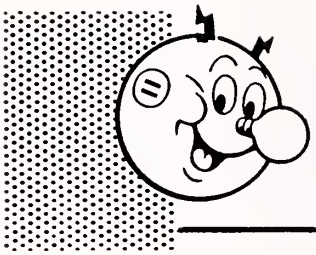
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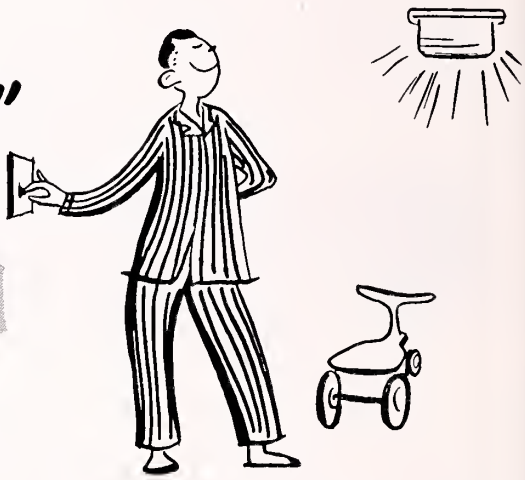


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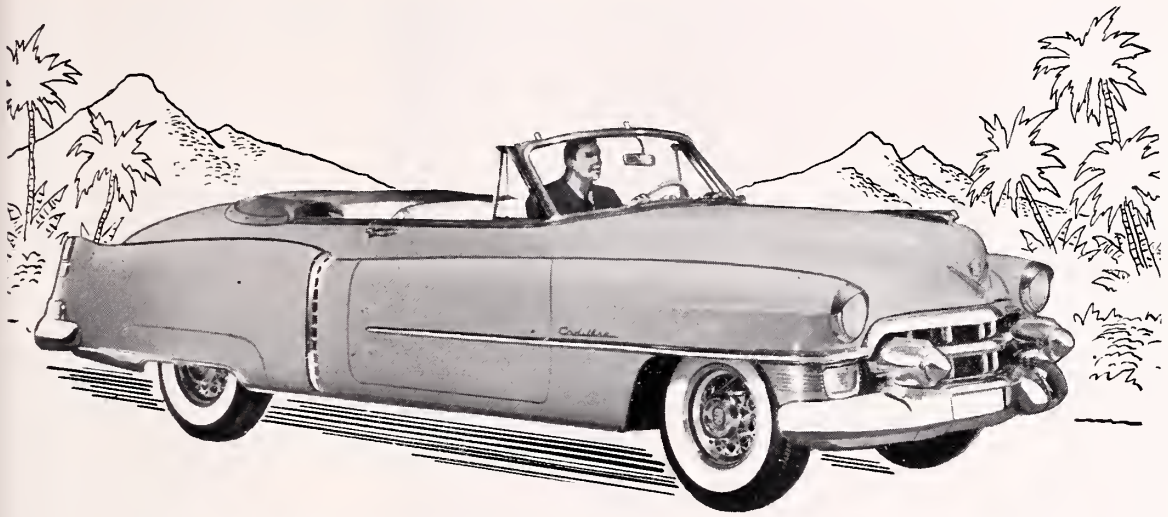
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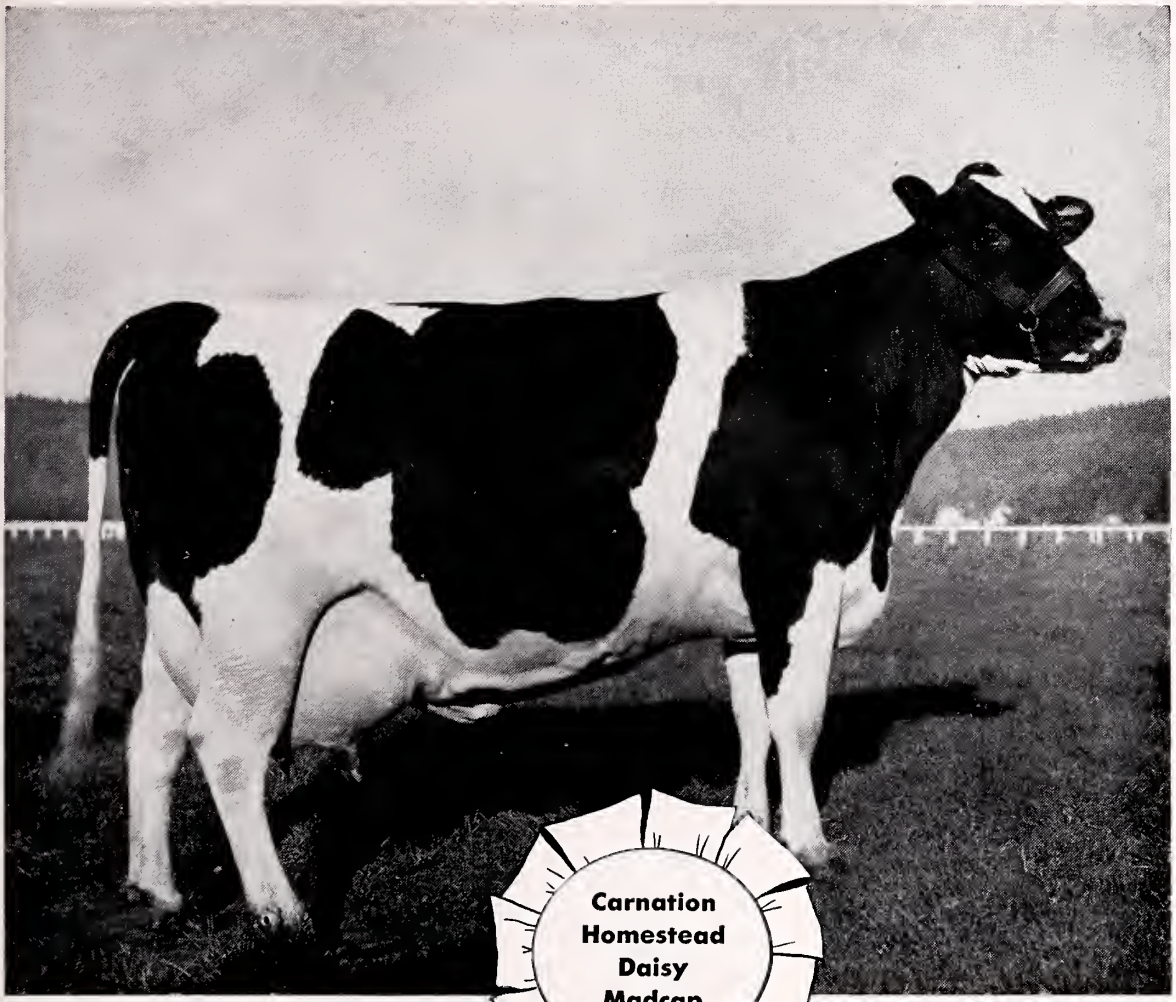
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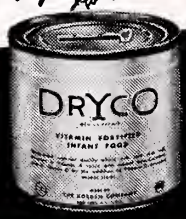
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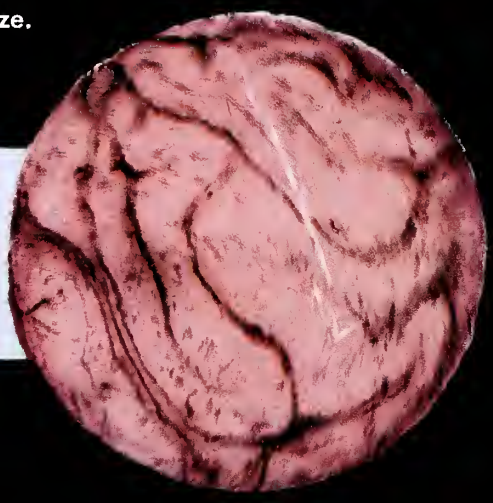


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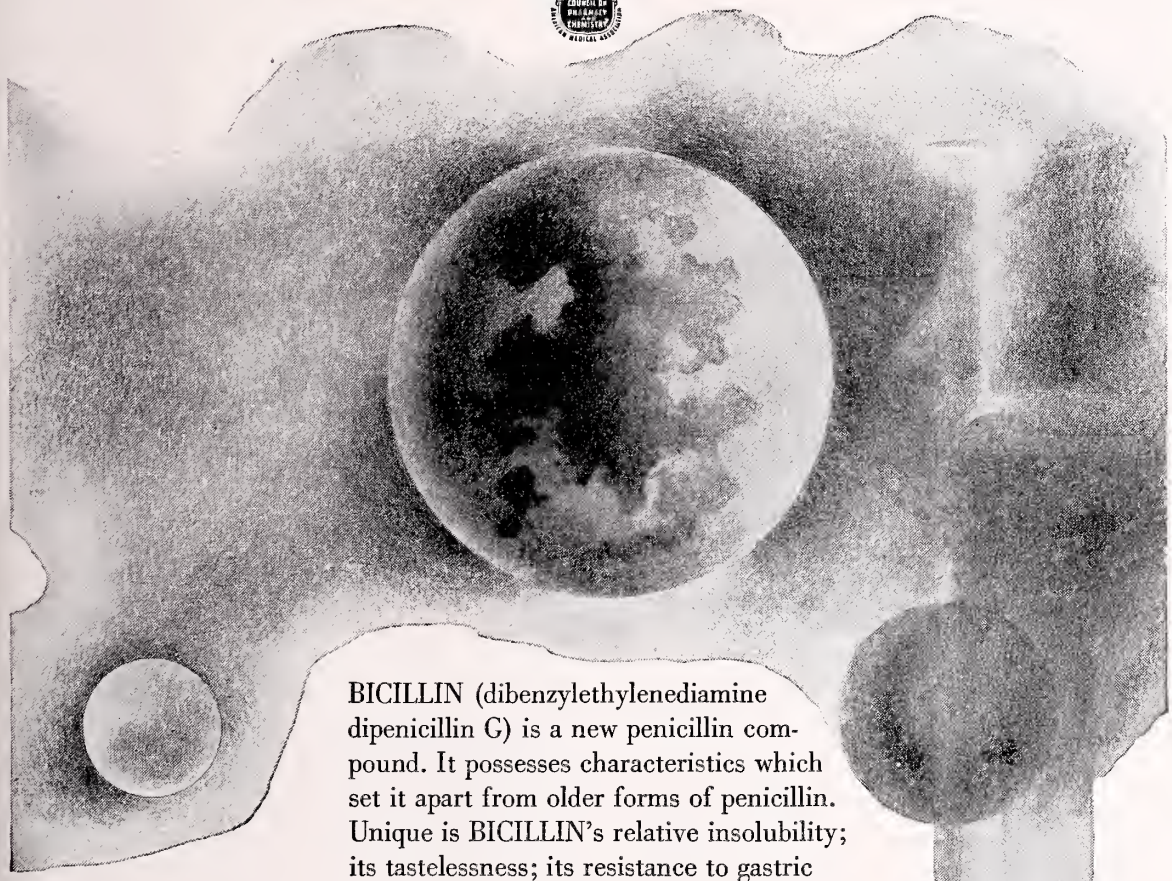
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POWDER

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# Bronchial Excision and Transplantation

PAUL W. GEBAUER, M.D.
HONOLULU

STUDIES done at various experimental surgical laboratories during the past thirteen years have indicated that the tracheobronchial tree of the dog is more than ordinarily receptive to proper surgical procedures. Successful instances of tracheobronchial surgery performed on human beings for the treatment of tuberculosis and post-traumatic strictures, defects arising from injury or the excision of newgrowths, and accidental surgical divisions of bronchi have been reported occasionally during the past five years. Dermal grafts have been used successfully at Leahi Hospital and elsewhere for the treatment of such lesions, particularly tuberculosis tracheobronchial stenosis, for the past five years, and in the last two and one-half years the writer has used a variety of tracheobronchial surgical procedures successfully in fourteen patients. In this experience five different methods of bronchial excision and closure or anastomosis were used, namely: sleeve resection, wedge excision, transverse closure with or without a bronchial flap, bronchial transplantation, and complete or partial bronchial division to facilitate dissection. This experience has been summarized and reported.[1] The purpose of this paper is to report an unusual case of tracheobronchial stricture due to healing tuberculosis in which tracheobronchial surgery provided an adequate airway and permitted salvage of an entire good lung.

## Case Report

J.T., a 28 year old woman, in January 1951 had an ulcerative tuberculosis involving the lower trachea, particularly in its right lateral aspect, and the right main bronchus. Four months of treatment with streptomycin and PAS (para-aminosalicylic acid) converted the sputum to negative and produced good healing of the tracheobronchial lesions. This was last noted bronchoscopically one year after the initiation of treatment, at the time of discharge from the hospital.

After an asymptomatic period of eight months, cough, wheeze, and a "positive sputum" recurred, again without any significant infiltration appearing in chest roentgenograms (Fig. 1, A). Bronchoscopy on November 10, 1952, revealed marked caseous exudate over most of the tracheal surface and heaped-up granulations on the anterior and right lateral tracheal walls. The severity of the process precluded examination of more than the proximal two-thirds of the trachea. Sputum cultures of tubercle bacilli were sensitive to streptomycin, which was given with INH (Nydrazid) and PAS. The patient's progress was satisfactory until January 17, 1953, when there was a rather abrupt increase in cough, wheeze, and sputum volume. A harsh wheeze and loud rhonchi were audible over both lungs. These symptoms gradually increased, until dyspnea became noticeable. Tracheal obstruction was obvious and bronchoscopy was repeated January 26, 1953.



DR. GEBAUER

A severe healing stenosis, especially involving the lower tracheal third, was encountered. There was no evidence of ulceration or caseous exudate. The tracheal mucosa was boggy and hyperemic. The upper portion of the thoracic trachea was rather soft and collapsible. A 6 mm. by 35 cm. standard bronchoscope was "wormed" down, and cocaine adrenalin solution applied to the mucosa. The tracheal stenosis was right above the carina, and the right main bronchial orifice was a minute opening about 2 mm. in diameter. The left main bronchus appeared normal.

Figure 2, B diagrammatically depicts the nature of the tracheobronchial deformity produced by the early healing phase of the severe tracheobronchitis, the involved structures being largely replaced by hyperemic, boggy, young fibrous tissue. The deformity was fairly well revealed in planigrams of the tracheobronchial tree.

Immediately following the bronchoscopy the patient's airway was much better, probably because of shrinkage of the edematous mucosa by cocaine and adrenalin. Although a tracheotomy was desirable to provide an adequate airway and as a safety measure, it was delayed because its presence would commit one to a reconstructive surgical procedure in the near future, that is, before antibiotic control of secondary infection was lost. This would be a matter of weeks, and it was felt that the stage of healing of the tuberculous process might not be receptive to reconstructive surgery in that time, and uncontrolled secondary infection would certainly be a detriment to any reconstructive procedure.

Shortly after bronchoscopy, however, increasingly severe tracheal obstructive symptoms returned and it was necessary to do a tracheotomy that evening. A low opening was made and the tracheal lumen was located with some difficulty; a long cane-shaped tube (Fig. 1, B), which bypassed the lower tracheal stenosis and entered the left bronchus, was inserted and provided marked symptomatic relief. The tube fitted snugly and

Read before the Sixty-third Annual Meeting of the Hawaii Territorial Medical Association, Wailuku, May 1, 1953.

[1] Gebauer, P. W.: Pulmonary Surgical Salvage by Bronchial Resection, S. G. & O. 94:347, 1952. Gebauer.[2]

[2] Gebauer, P. W.: Bronchial Resection and Anastomosis. Presented at annual meeting of the Association for Thoracic Surgery, San Francisco, California, March 27, 1953. To be published in *Journal of Thoracic Surgery*.

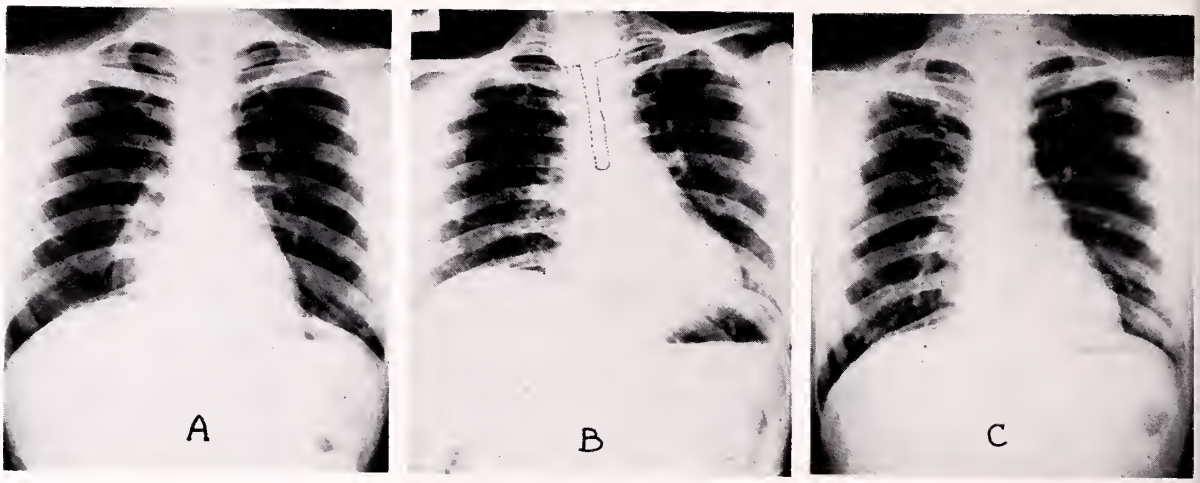



Fig. 1. A, chest roentgenogram following second hospital admission, November 21, 1952. Severe ulcerocaseous tuberculosis of trachea and right bronchus. Lung fields clear except for suggestion of partial atelectasis medial right base. B, Jan. 27, 1953, 12 hours after tracheotomy to bypass asphyxiating stenosis of lower trachea. The long cane-shaped tube is outlined; it approximates the orifice of the left bronchus. C, April 13, 1953, two months after thoracotomy, excision of right main bronchus, and correction of lower tracheal stenosis by transplantation of right upper and lower bronchi into lower trachea. (See Fig. 2.) Both lung fields clear.

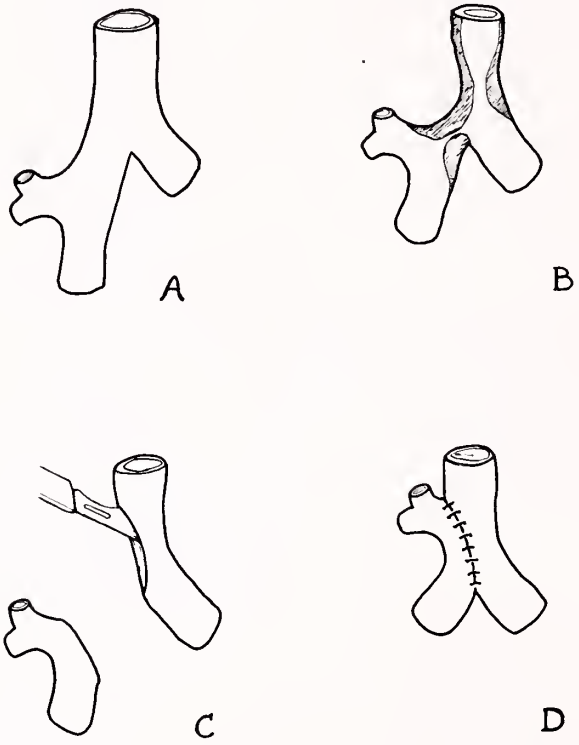



Fig. 2. Diagrams illustrating deformity produced by healing tuberculosis of trachea and right bronchus, and surgical treatment used. A, normal tracheobronchial bifurcation for comparison. B, stenosis of trachea, severe in lower third, practical occlusion of right bronchus. C, right bronchus excised forming a large double-barrelled unit consisting of upper and lower bronchi. Tracheal stenosis opened by longitudinal incision. D, lower trachea enlarged by transplantation and anastomosis of upper and lower bronchi into tracheal incision. Right lung salvaged.

permitted no air to come through the larynx even with violent coughing.

The patient gradually became accustomed to the tube, secretion lessened, and her general condition improved. Breath sounds were diminished or absent over the right lung; however, it did not become atelectatic, and both lungs remained clear radiologically. Antibiotics apparently prevented any significant secondary infection of the tracheostomy.

On February 13, 1953, seventeen days after tracheotomy, a posterior right thoracotomy was performed. The long tracheotomy tube was replaced with a soft plastic intratracheal anesthesia catheter, which was sutured in position. The operative procedure is diagrammatically depicted in Figure 2, C and D. The entire right bronchus consisted of rather fleshy fibrous tissue with no demonstrable lumen. It was excised from the tracheal carina to a point distally that transected both the upper and lower lobe bronchi. At this level the transected bronchi appeared quite healthy, and they formed a large double-barrelled structure. The skin suture in the neck, fixing the tracheal tube, was released, and the tube then guided into the left bronchus for continued aeration and anesthesia. The most severe portion of the tracheal stenosis, above the carinal level, was then opened by an incision in the right lateral tracheal wall extending upward from the carina for about 4 cm. The tracheal wall consisted of edematous fibrous tissue, no cartilages were encountered, and no caseous material or other exudate seen. A small strip of somewhat cellular tissue was removed from the anterior margin of the incision.

The right inferior pulmonary ligament was then divided and the lung hilum displaced upwards. The upper and lower bronchi, as a single, large, double-barrelled unit, were then sutured into the tracheal incision. The addition of this structure to the circumference of the lower trachea notably increased its lumen. The anastomosis was done with a single layer of simple, interrupted sutures of multistrand, atraumatic, 00000 wire; it was airtight. The tracheal catheter was then drawn back into the trachea from the opposite left bronchus, and the right lung readily inflated. The chest

was closed with suction drainage. The tracheal catheter was replaced with a short, standard, No. 4 tracheotomy tube.

The patient did well after operation; bronchoscopy was done eight days, nineteen days, and eight weeks after operation. Good healing, without much exudate, was noted. Hyperemia, edema, and mucous secretion gradually lessened. The lower lobe bronchus admitted a standard 7 mm. bronchoscope; the upper lobe orifice could be partly visualized and appeared adequate. Good breath sounds were continually audible over both lungs. The short tracheotomy tube was removed one week after operation. The patient's sputum continues negative for acid-fast bacilli on concentrate and culture. Both lung fields remain clear radiologically (Fig. 1, C). Streptomycin, PAS, and Nydrazid are to be given for a long period. Other antibiotics were discontinued two weeks after operation. The patient is now four months postoperative, practically asymptomatic, and comfortably continuing her treatment on a semi-ambulant regimen.

The right bronchus and portion of the trachea removed at operation showed non-specific granulomatous inflammation on routine microscopic section. It is felt that long, intensive use of antituberculous drugs may necessitate serial microscopic sections to reveal the usual histologic criteria for tuberculosis in healing tuberculous tracheobronchial tissues.

Leahi Hospital.

# This Era of Anxiety

R. J. McARTHUR, M.D.
WAILUKU

OUR GENERATION is living in an era of world revolution—a period of rapid change. There is ubiquitous concern about our situation, for we as individuals have no knowledge of our personal destinies. This lack of insight into a troubled future nurtures a universal anxiety. Our emotional calm is everywhere contaminated with anxious expectancy. Historians are already classifying our generation as an Era of Conflict. From the standpoint of our profession we might well call this period an Era of Anxiety.

A more intimate knowledge of the atom has ushered in this new age with the abruptness of the Hiroshima blast. Words such as strain, stress and tension are being underlined in our vocabulary. Fear, fright and frustration are becoming common experiences of our people. Apprehension with its anticipation of impending danger permeates our emotions. We may fear our future but we feel helpless in stabilizing our course. Our general environment stimulates anxiety.

While we strive and sacrifice for peace, we are chilled by the breath of war. We are puzzled by a cold war that spills the hot blood of our youths. We are anxious about our personal safety and that of our children and our children's children. As we contemplate a new war with the instruments of devastation science has placed at our disposal, we simultaneously realize its futility. The thought upsets our stability. Small fires scattered around the globe may at any time spread and unite into a conflagration that may well stifle us. International unrest—global anxiety.

We witness open and insidious inroads of a type of ideology we consider immoral and amoral. We experience emotional shock at the many examples of tyranny brought to our attention. We figuratively tremble at the danger Communism presents. We shudder at the attacks made upon our freedom. We are disturbed about the preservation of our democracy and our dignity. We ponder the increasing subjugation of unsettled and defenseless nations. Indeed Russia is playing a major role in this drama—in this Era of Anxiety.



DR. McARTHUR

We witness an incomprehensible national debt continue to increase. We worry about the calibre of the men entrusted with the navigation of our ship of state. We are deeply concerned about corruption in high places. There is even a sense of insecurity in our attempts at social security. We question the effects of centralized power in government upon our personal liberties. We are nervous about the amendments being made in our democracy. Our government is contributing to a national anxiety.

The more taxes we furnish for military security, national ventures and international aid, the less funds are at our disposal to manage our own business problems. American know-how and the skill of mass production have given to us material nice-

Presidential Address to the Sixty-third Annual Meeting of the Hawaii Territorial Medical Association, Wailuku, May 1, 1953.

ties about which our forebears only dreamed. We now consider many of them necessities. When higher taxes and higher costs prompt a continual tugging at our economic belts we are frequently overtaken with and submerged by financial inadequacy. We rob our future security to pay for our present material appetite. We wonder if our life's savings will support our needs on the last lap. The end result is economic anxiety.

We are cognizant of these and many other factors contributing to emotional instability in our patients. More and more are we listening to psychic and emotional symptoms. Less and less are we able to eliminate somatic disease alone and effect a cure. The specialty of psychiatry is rapidly increasing in volume. Anxiety is most always lurking somewhere in psychiatric problems. Medical men are not entering this field in sufficient numbers to prevent the appearance of the charlatan, the quack, the spiritualist and the soothsayer. It appears doubtful that enough physicians can enter this field to satisfy the demands. It is time for physicians in every type of practice to shoulder some of this responsibility. No specialty is immune to this growing neurosis. No system of the body escapes. The functional cardiac conditions, the part of emotions in the etiology and treatment of peptic ulcer, the biliary dyskinesias, the spastic colon, the premenstrual tension, the precipitation of toxic thyroid states and the stress group of skin maladies are a few common examples. The pediatricians are becoming more and more aware of factors which might underlie a neurosis later in life. It is clearly the duty of all physicians to be cognizant of and to treat the symptoms associated with any abnormal life situation.

We may well ask ourselves why this problem is new in our present generation. Are we losing our grip? Are we getting soft? Were our forebears made of sterner stuff? Undoubtedly anxiety neurosis under some different names has been present through the ages. It is most likely only a matter of degree. The pioneers feared the Indians and King Arthur's knights feared their opponents. But they could see their enemies and had something tangible to combat. In this complicated society our enemy is hidden, and fear of the invisible nurtures frustration, insecurity and anxiety. However we may excuse ourselves, the problem is present.

What are we to do about it?

We can spend more time analyzing our patients as human beings. We can force ourselves to take more time. We can stop referring our patients to the psychiatrist until the problem becomes too much for us. We can stimulate our knowledge by more papers, clinics and round table discussions. We can attempt to help the public and many health agencies lessen the stigma attached to this type of ailment.

Symptoms from a hyper-irritability of the autonomic nervous system are common knowledge to the profession. We are all familiar with the morning fatigue even after a sound sleep, the feeling of nervousness, the pounding heart, the tightness in the chest, the lump in the throat, the cardiac pain well to the left of the sternum, the gas "on the stomach," the alternating loose and constipated stools, the insomnia, the numbness and tingling in the hands and feet, the sweaty palms, the indefinite diffuse backache and similar symptoms.

Not so many years ago we were convinced we had the answer if we could discover a new drug. We knew that atropine and atroprine-like drugs would paralyze the parasympathetic nerve endings. We knew that pilocarpine, physostigmine and like-acting drugs would stimulate these parasympathetics. We knew that adrenalin and adrenalin-like drugs would stimulate the sympathetic nerves. But, alas, we had no drug to paralyze the sympathetics. With such a wonder drug we would have the situation in hand. We could add a pinch of atropine or a dash of pilocarpine or a bit of the unknown and juggle this delicate balance between the sympathetics and the parasympathetics in any individual case and presto, the neurosis from the emotions would be hunky-dory. Then someone discovered gynergen, a drug to paralyze the sympathetic nerve endings, the drug for which we were yearning. But it seldom worked. We seemed unable to find the exact amount of any of these four drugs to balance the irritability in these two components of the autonomic nervous system. Bellergal was suggested—the hyoscine to deaden the parasympathetics, the gynergen to deaden the sympathetics and the phenobarbital to deaden the cerebral impulses. Some relied on cerebral depressants alone. At best these drugs were only crutches. Even when successful, the control of an anxiety neurosis with medicine was like the control of an acute appendicitis with morphine. The cart was before the horse.

With this sad let down we were aware that we must find the cause of this hyperirritability of the autonomic nervous system. An endeavor must be made to eliminate the etiology. If this were not possible our patients must be educated to adapt themselves to their life situations to the end that

their insecurity, their anxiety and their frustrations be lessened.

We finish a complete impressive physical examination. We tell our patients we find no organic trouble. We explain the relation of the autonomic nervous system to their frustration and their anxiety. We explain that their symptoms can be but partially alleviated unless we can unearth the emotional factors responsible—the reasons for their anxiety, frustration, and insecurity. It is as useless to tell our patients that they need only to control their nerves as it would be to ask them to control their heart beat, their respiration or their digestion. We cannot tell them there is nothing wrong when there is. It is useless to tell them to pay no attention to their symptoms when they are unable to control them.

We make clear the type of emotional disturbance responsible for their autonomic nervous system irritability and then we sit back to listen. In most cases they answer their own problem immediately. Seldom is it necessary to probe into how soon they were housebroken, how secure they were during the first year of life, or whether strict parents were setting the stage for a compulsion neurosis in later life. Rarely is it necessary to call for the specialist in psychiatry to unearth some dormant or hidden explanation.

Perhaps the initial etiology has ceased to exist and the anxiety is nurtured by the frustrating symptoms themselves. There is present a vicious circle. They seek out anyone or grasp at any possibility for relief. Still the symptoms persist. The more the symptoms the more the frustration and the more the frustration the more the symptoms. They are not driven away with a whip. They are not cured by shock. They are often more perplexed by a sojourn in a mental institution. What they actually need is an insight into the emotional factors stimulating the symptoms, given them during a discussion with their own private physician, no matter what his specialty. We doctors may be able with patience and consideration to outline a course for them by practical suggestions into which they can sink their teeth.

In the case of those who are unable to eliminate the factors leading to this symptom complex, the plot thickens. The challenge is greater but the responsibility is no less. To guide our patient in an endeavor to adapt and adjust to an unalterable situation may tax our ingenuity but should not dampen our endeavor.

General philosophy may come to our rescue. Standards may be too high; social and economic eminence is not a necessity for security. Are we urged into living in the future, forgetting present and oblivious to the past? Are we carrying all the burden because we are unable to delegate authority? Are we adversely affected by contagion from a tense environment? Are we too busy to formulate new ideas? Are we evaluating our situations with due perspective? Are we viewing this stormy little episode in our life in relation to its significance in a five or a ten year period; weighing the present in respect to time? Are we concentrating on one thought at a time or are we jumping from one to another trying to solve them all at once and ending in a quandary? Are we carrying over our tension business routines to our hobbies developed primarily for relaxation? Are we so overcome with so many tasks that we procrastinate the tackling of one? Are we allowing ourselves to be swept along with the ever present current of competition? Are we allowing ourselves to become slaves to specialization? Are we racing against time? Do we lack faith in immortality? Have we forgotten the potency of love? Are we overlooking, be it Buddha, Christ, Mohammed or an idol, the possibility of the value of a personal deity to whom we can talk over our troubles in prayer and from whom we can cultivate self reliance and eliminate our tendency to blame our misfortune on our fellows?

To those of the medical profession who do not feel that they can spend the time necessary to lend an uplifting hand to the emotionally disturbed, let me offer a suggestion. Write out an address as I have done, in your own words and on the same subject. Present a copy to your emotionally disturbed patient with a passing remark that tells him you do not look upon him as a collection of organic mechanisms but as a human being.

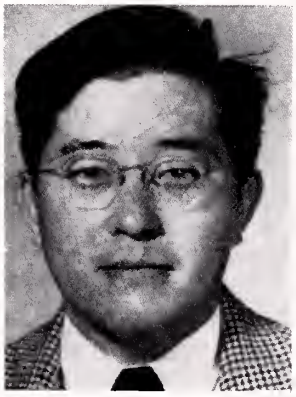
We of the medical profession have a job to do in this Era of Anxiety.

# Osteofibroma of the Lower Right First Molar Region

## Report of Case

JOSEPH C. TAM, D.D.S., M.S.D.
MINNEAPOLIS

AN osteofibroma was completely enucleated on July 27, 1948, from the lower right first molar region of a white girl, Miss I. H., age 17. The patient had noticed an enlargement in the right posterior region of the body of the mandible a year before. The growth was slow and painless. A month before, her local dentist had advised her that the growth should be treated.



DR. TAM

Her general health was good. On questioning, she disclaimed any knowledge of parathyroid dysfunction.

*Examination:* She was a young girl well developed and well nourished. She was not mentally upset. There was no visible swelling or asymmetry of the face (Fig. 1). The lesion in the right body of the mandible measured 2 cm. in diameter from the distal of the first bicuspid to the mesial of the 2nd molar. It felt hard and



Fig. 1. Pre-operative view of face showing no asymmetry.

oval in shape on palpation from the buccal aspect (Fig. 2). No sinus or fistula was seen. The surrounding gingivae were healthy. The lower right second bicuspid and both the lower right and left first molars were missing. The lips, tongue, throat, palate, and buccal cavities were negative. The saliva was of normal consistency.



Fig. 2. Intra-orally a hard and oval shaped mass is seen from the buccal aspect.

*Roentgenographic Examination:* A dental roentgenograph taken when the patient was about ten years old revealed the beginning of a radiolucency just mesial to the lower right first molar retained roots. The second bicuspid was mesial of the lower right first molar retained roots, but was embedded quite deeply (Fig. 3).

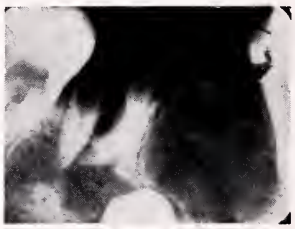


Fig. 3. X-ray taken when she was ten years of age showed the first evidence of the lesion.

Recent dental and lateral jaw roentgenographs showed a semicircular radiolucent area about 2 cm. in diameter. On comparing the x-ray in figure 3 with that of figure 4, one can see that the lower right second bicuspid had been displaced distally by the lesion's growth. A pericoronal sac was distinctly seen on the mesial surface of the embedded second bicuspid. The border at the inferior surface was diffuse and radiopaque particles about 2 mm. in diameter were seen within the radiolucency (Fig. 4).

School of Dentistry, University of Minnesota.
Received for publication March 9, 1953.

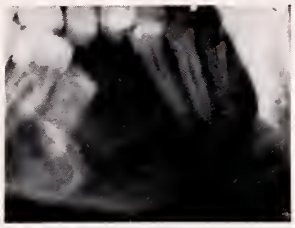


Fig. 4. X-ray taken on day of surgery revealed a diffuse type of radiolucency infiltrated with irregular islands of bone.

A hematologic study revealed the following: Hemoglobin count 12.5 gm., White blood count 7,300; Bleeding time three minutes; Clotting time three and one-half minutes. The vitality readings on an electric pulp tester were eight for the lower right second molar, eight on the lower right first bicuspid, and four lower right on the cuspid.

On July 27, 1948, the inferior alveolar, lingual, and long buccal nerves were anesthetized with 1½% monocaine. Two elliptical incisions about 1 cm. long and 2 mm. apart were made on the buccal gingivae down to bone. A chisel and mallet were used to remove a section 1 cm. deep. On removal of this section, a whitish soft material was seen in the cavity. This was not a distinct dentigerous cyst grossly. It was anticipated at this time that the entire lesion could be completely enucleated inasmuch as the growth was enclosed within a well defined capsule. Complete removal of the growth was assured by visual inspection and repeated curettage.



Fig. 5. Post-operative view 14 days after surgery. The opening of the wound measured one centimeter in diameter and is healing by secondary intention.

When surgery was completed, the cavity was partially filled with oxidized cellulose (Oxycel; Parke, Davis) and further pressure applied with gauze sponges.

*Microscopic Report:* The lesion consisted of a mass of fibrous connective tissue with a large number of spindle-shaped cells arranged in whorls, and irregular bone spicules in various stages of development. Collagenous fibers were also seen between the spindle-shaped cells (Fig. 6). Diagnosis: osteofibroma.

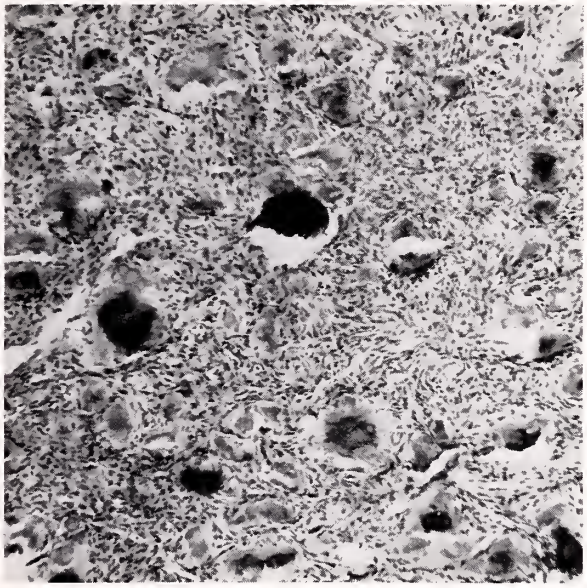


Fig. 6. Photomicrograph showing fibrous connective tissues, spindle shaped cells arranged in whorls, and irregular bone spicules in various stages of development.

## Comments

It is not logical to diagnose a pathological lesion from either the objective and subjective findings or from a roentgenographic study. This fact is very well brought out in this case history. Our objective and subjective findings indicate that the lesion was a slow growing one and within bone. A cursory examination of the roentgenograph reveals a radiolucent area, which brings to mind instantly the most likely diagnosis, namely that of a cystic lesion. However, a conclusive diagnosis necessitates a biopsy. Such a procedure offers the patient the best treatment plan, the least danger of recurrence, and the best opportunity for recovery from his disease.

# Third Generation Syphilis

C. V. CAVER, M.D.
HONOLULU

THE CONCEPT of third generation syphilis has long held a precarious position among syphilologists. Early authors reported a high incidence and later observers have shown widely varying figures on its occurrence.[1] Since the acceptance of established criteria for verifying these cases, fewer appearances have been noted in the literature. In modern syphilology the use of quantitative serologic methods has injected a new factor into the evaluation of all forms of the disease. No mention of quantitative determinations of reagin titer occurs in any of the reported cases. The weakness in all alleged cases of third generation syphilis reported has always been the possibility of reinfection or superinfection of the congenitally syphilitic mother and subsequent affliction of the fetus from this source. The excellent studies of this condition by Hahn[2] and Allison[3] indicate that in most of the reports of congenital syphilitics who became reinfected the diagnostic evidence was inadequate and principally presumptive, but they present four authentic cases of maternal reinfection nevertheless. Allison predicted that reinfection of congenital syphilis would become increasingly frequent.



DR. CAVER

The criteria for establishment of third generation cases used by most authors apparently assume a program of rigorous morality for all those involved in the chain and the possibility of reinfection of the congenitally syphilitic mother from whatever source is not ordinarily included. The Fournier-Finger system of criteria does take this possibility into consideration.[4] With the availability of better case-finding systems and quantitative serologic follow-ups in treated syphilitics, it is probable that more light will be thrown on such cases in future. Better reporting and case study will eliminate many spurious instances of otherwise apparently congenital infection's being transmitted to the third generation by mothers who are assumed to have uncompounded congenital syphilis themselves. The following case is reported to illustrate how such spurious third generation syphilis may be clarified by thorough investigation, principally quantitative serologic observation.

Received for publication February 19, 1953.

[1] Beerman, H., Wammock, V. S., and Magnuson, K. B.: Third Generation Syphilis, Am. J. Syph., Gonorrhea & Venereal Dis. 26: 504 (July) 1942.

[2] Allison, S. D.: Reinfection in Congenital Syphilis, Am. J. Syph., Gonorrhea & Venereal Dis. 26:212 (March) 1942.

[3] Hahn, R. D.: Reinfection in Congenital Syphilis, Am. J. Syph., Gonorrhea & Venereal Dis. 25:200 (March) 1941.

[4] Stokes, J., Beerman, H., and Ingraham, N.: Modern Clinical Syphilology, Philadelphia, W. B. Saunders Co., 1945, p. 1081.

## Case Reports

CASE 1. A.M.M., a negro girl, aged 4½ months, was admitted to a children's hospital on 6/2/49, with a history of "snuffles" and a macular rash appearing one week after birth. Bullae and desquamation occurred on the palms and soles, followed by patchy alopecia of the scalp. At admission the skin was dry with diffuse, scaly, macular, slightly erythematous lesions of the axillae, chest, inguinae, popliteal spaces, and backs of the legs. The facies was that of a worried old woman and was dominated by a saddle nose. Seropurulent rhinitis presented a constant nursing problem. There was extensive desquamation of the palms and soles, and maceration of the macules in intertriginous areas, but no oral or anal lesions. Unfortunately no darkfield examination was done and penicillin had been given for the rhinitis. The case was followed by the writer after consultation.

Weight on admission was 10 lbs. and diarrhea was reported from birth. Admission Eagle Flocculation was 3 plus, Wassermann 4 plus. The spinal fluid showed 48 mg% total protein, trace of Pandy's globulin, sugar and chlorides normal, 8 monocytes and two P.M.N., Kolmer Wassermann positive in 3 tubes, colloidal gold negative. A repeated spinal fluid examination a few days later showed no significant change. The blood showed 9.6 gms. hgb., 3,000,000 rbc., 13,900 wbc, 53 adult P.M.N., 4 band cells, and 43 lymphocytes. A total of 3,300,000 units of penicillin was given over a period of fourteen days, with resolution of the skin lesions and rhinitis and a provocative rise in serologic titer, the quantitative Wassermann being 4 plus in nine tubes and the Eagle Flocculation 4 plus in all dilutions done (1:1, 1:2, 1:4). Radiographic studies showed periosteal thickening of most of the long bones indicative of congenital syphilis.

CASE 2. R.M.M., a negro woman, aged 18, mother of A.M.M., was sent to the Dallas Venereal Disease Clinic from the children's hospital, where she had volunteered the information that she had had "sores" on her legs, vulva, and feet during her childhood and was merely waiting for her child to pass through this condition as she had. She was told by her maternal grandmother that she had been born with "bad blood" contracted from her mother. Neither R.M.M. nor her mother had ever had any treatment or previous STS (serologic test for syphilis). R.M.M. had suffered a miscarriage at 5 weeks in April, 1948, but A.M.M. had been born after a "normal" pregnancy. On examination she presented marked frontal bossing and depression of the nasal bridge. There were atrophic, depressed, circular scars on both legs and a solitary, tender, right postauricular

lymph node. Peg-shaped, notched, Hutchinsonian incisors were present, as well as five mulberry molars (extra cusps, turreted cusps). Kline reaction on 6/3/49: 4444441. The quantitative Mazzini showed the zoning phenomen often seen in congenital syphilis: 1244441. Kahn units were 64 and the qualitative Wassermann was positive. She was treated at a United States Public Health Service rapid treatment center with 4,800,000 units of penicillin over a ten-day period. The post-treatment serologic status on 7/11/49 was Kahn 64 units, Kline 444441, Mazzini 44443. The serological status on 8/1/49 was Kahn 256, Kline 244443, Mazzini plus-minus 44442, Wassermann 44.

CASE 3. H.M., Male Negro, 28, husband of R.M.M., was investigated along with his wife. He gave a history of 6 or 7 intravenous injections for syphilis in 1943. The diagnosis of syphilis had been made without benefit of STS, and he reported that his only complaint at the time was a solitary inguinal lymph node. He stated emphatically that there had never been a primary lesion. A subsequent STS in 1946 was reported as negative. His serologic status on 6/21/49 was Wassermann positive, Mazzini positive, and quantitative Kline 44444. There was no physical sign of syphilis. He denied extramarital exposure and assumed that his present status was derived from his wife. He was treated at a U.S.P.H.S. center wtih 4,800,000 units of penicillin over a ten-day period. Spinal fluid was normal. His Kahn two weeks after treatment was ±244444, indicating a provocative rise in titer characteristic of early syphilis.



*FIRST INTERN, FIRST FLAG—At its campaign inauguration dinner for the current drive to raise the final $600,000 to build a new surgical wing at The Queen's hospital officials introduced Dr. Homer Hayes as the kamaaina institution's first intern. He started his final studies there in 1906. Behind him is shown the first hospital flag known to be designed in the United States. It was created by Dr. Nils P. Larsen, former hospital medical director, and utilizes the crown of royalty (who founded the hospital in 1859) and the inverted E's monogram of Queen Emma. The colors are red and gold on a white field. (Camera Hawaii photo.)*


## Summary

A case of undoubted congenital syphilis of the newborn is presented which would superficially appear to be an instance of third generation syphilis transmitted directly through the congenitally syphilitic mother. The history and physical findings in the mother would possibly have supported this view had there not been sufficient investigation of the husband and mother. Quantitative serologic titration of both patients before and after treatment indicated early syphilis in both. Consideration of the probable social behavior suggests that the wife was reinfected extramaritally or premaritally with subsequent transmission to the husband, or, equally likely, that the husband was in relapse from his original infection and infected his wife according to Schoch's principle of "ping-pong" syphilis.

It is felt that third generation syphilis did not occur here and that similar study and consideration of such cases will eliminate reporting of some future spurious cases of third generation occurrence.


1124 Alakea Street.

## QUEEN'S DRIVE FOR FUNDS

The public subscription campaign to raise the final $600,000 needed to provide a new surgical wing at The Queen's hospital is well under way among all classes of business and professional men and will end August 15 after a residential campaign is terminated, Dr. Joseph E. Strode, general chairman, has announced.

First to memorialize sections of the new building was a retired physician, Dr. T. L. Wong, who gave $10,000 under a new living memorial plan developed by hospital officials.

The total cost of the entire development at the kamaaina institution will be about $1,400,000. In addition to 14 new operating rooms, a 12-bed post-operative recovery ward, an auditorium seating 80 for lectures and visual education, the new wing allows the removal of the pediatric unit into fire resistant quarters with 40 beds instead of its present 39 and inclusion of an isolation unit; use of former operating rooms as an expanded laboratory with additional research rooms; addition of 106 new beds with replacement of 84 declared unacceptable; removal of the outpatient clinic to largely expanded quarters in older wings; building of a new incinerator to replace the one presently condemned.

Dr. Forrest J. Pinkerton is heading the solicitation of funds from professional groups in the islands.

Several pieces of informative literature are available for the full study of interested persons. One deals with tax savings that can be made through the giving of funds to non-profit hospitals such as The Queen's; another explains the new living memorial plans and a third is of a general nature explaining in full why The Queen's must build to maintain its acknowledged position as the medical center of the Pacific area.



# *The President's Page*

It is indeed a great honor to serve as President of the Hawaii Medical Association, and I have accepted that responsibility with the full knowledge that the challenging future has in store an abundance of vexing problems. Some of these problems are known but many are barely visible around the many curves in tomorrow's pathway. On the threshold now are perplexing situations concerning the subject of medical economics. Vast areas remain to be explored and studied in this interesting and important field. Such features as uniform fee schedules which are applicable in all counties should evolve from these surveys.

In order to properly resolve any problems that arise it will be vitally necessary to have the full cooperation of every member of the association. I humbly request that cooperation.

There are a very few within our organization who have forgotten our Code of Ethics, and the time has come for an accounting. In conformance with the policy of the American Medical Association I should like to urge the county societies to establish more rigid ethical requirements for membership. I should like to urge the county societies to consider revisions or amendments to their by-laws to provide for more stringent regulations for disciplining unethical members. The Code of Ethics of our parent organization, the American Medical Association, is our guide and all members should have an opportunity to review that code. To familiarize new members with the principles and ethics of good medical practice, it is suggested that the county societies initiate indoctrination conferences for all applicants to membership.

This administration will cooperate to the fullest extent of its ability with all private and governmental health agencies in providing advice and guidance in the various fields of medicine.

Medicine is our business, and our mission is to provide the highest quality of medical service to all the people of Hawaii Nei.

Aloha,

R. L. Cluingstoon, M.D.

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# [EDITORIALS]

## DR. RICHARD K. C. LEE: A WISE CHOICE

Dr. Richard K. C. Lee, Assistant Health Executive of the Hawaii Territorial Department of Health since 1943, and prior to that Deputy Commissioner of Public Health since 1937, has been appointed President of the Board of Health to succeed Dr. Wilbar. His appointment was confirmed by the Senate on May 25.

Dr. Lee is a graduate of McKinley High School and the University of Hawaii; he received his M.D. from Tulane in 1933 and the degree of Doctor of Public Health from Yale in 1938.

Ten years ago this month Dr. Lee was said in these columns to be an "estimable young man of ability and character [with] training and experience which should qualify him well as a public health administrator." He still is—our definition of "young" has broadened a little, and the other qualifications mentioned have increased with the years.

Governor King's selection of Dr. Lee to fill this important position deserves—and, we feel sure, has received — the medical profession's enthusiastic endorsement.

## FREE CHOICE OF PHYSICIAN?

Who should choose the doctor in Workmen's Compensation cases—the injured workman, or the employer?

Family doctors and some solo specialists not often chosen by employers for the treatment of industrial accident cases have long felt—with justification—that (1) they were in general just as competent as the company doctor, and should be allowed to treat (or refer) their own patients, at least, for industrial injuries, and (2) that a doctor already familiar with the patient's medical background, idiosyncrasies, previous illness, and so on, could do a better job than one to whom the patient was a stranger. Moreover, they have pointed out that organized medicine has long stood for the principle of free choice of physician by the patient.

Most employers have felt, on the other hand, that because (1) they were paying the bills, and (2) they had a large financial stake in the prompt and complete rehabilitation of the injured workman, they had a moral obligation (as well as a legal right) to insist on treatment by a physician of their own selection. Only in this way could they insure, they felt, that the medical care would be as competent as possible and that the doctor's attitude would be that the man must return to work just as soon as he was reasonably able.

House Bill 692 (House Draft 1, Senate Draft 2), passed by the last legislature and vetoed by Governor King, would have transferred the right to choose the doctor from the employer—who has had it by law since 1915—to the workman, *if:*

1. The employer did not maintain a medical plan under the provisions of a collective bargaining agreement, *and*
2. The employee wished to select a physician "in his immediate vicinity" (not further defined) other than the one provided by the employer—*or* if "emergency or other justifiable cause" (in the subsequent opinion of the Director of Workmen's Compensation) required the selection of such a doctor; *and*
3. No "surgical or specialist services" — these not being otherwise defined—were required.

The exercise of "free choice" by the workman under circumstances not subsequently approved by

the Director would have deprived him of his right to have the medical care paid for by the insurance carrier—a manifestly unfair arrangement. In addition, the bill actually provided that the Director could approve payment for services if he found they had been rendered *or* [italics ours] that "emergency or other justifiable cause" existed!

The problem is a complex one, and House Bill 692, with its last-minute patchwork of unclear and contradictory amendments, was not the answer to it. A committee has been appointed by the Governor to explore possible answers. It is to be hoped that they will come up with a practical solution to the difficulty in time for its presentation to the 1955 legislature in the form of legislation which will be acceptable to all groups involved.

## REHABILITATION OF THE APHASIC PATIENT

Motor aphasia, inability to speak or write following a cerebral vascular accident, is a terrifying experience. It may not be permanent, however—and it seems probable that sustained efforts at rehabilitation and relearning the lost abilities may help to prevent it from becoming so.

Whether this is true or not, aphasic patients can be relieved of their panicky, cut-off feeling and made relatively happy if they are patiently trained in a simple method of communication by hand signs. Such a method was invented some five years ago by Hamilton Cameron, a doctor of both medicine and philosophy, who in 1943 became aphasic as a result of a cerebral embolism.

This chart was published in the *Medical Times* in November, 1950, and reprinted in *Arizona Medicine* in August, 1952. It is copyrighted by Dr. Cameron, but he will furnish copies of it gratis upon request. It contains simple hand signs signifying "no," "yes," "I'm thirsty," "I want my glasses," "I didn't understand," and so on.

Dr. Cameron's address is 601 West 110th Street, Suite 3LL, New York City 25, New York.

## BACTERIAL WARFARE AND THE BIG LIE

The accusation that the United States has carried out bacterial warfare against Communist China and Korea occupies 660 pages of a triple issue (Sept.-Dec., 1952) of the *Chinese Medical Journal*. Quite apart from the fact that bacterial warfare is regarded as inhumane and detestable and of doubtful effectiveness and practicability, and that accusations of misconduct by their opponents have long been a familiar part of the pattern of Communists' misbehavior, this particular accusation is about as silly, in two ways, as could well be imagined.

In the first place, it is silly because it is so complex. The U. S. is accused of implanting not just two or three diseases, but 7 human diseases (plague, anthrax, cholera, typhoid, paratyphoid, bacillary dysentery, and a hitherto unknown virus encephalitis), one fowl disease (Pasteurella multocida infection), and 4 plant diseases. For this purpose we are said to have used 6 kinds of insects, 2 marine animals (clams and fish), and 7 inert vehicles (feathers, 4 kinds of plant leaves, lyophilized culture media, and an aerosol). In addition, it is claimed that we dropped 10 different kinds of non-infected insects, including such curious selections as non-biting stable flies, field crickets, and springtails, and 2 kinds of tree leaves (laurel and oak) not carrying any plant pests.

The second absurdity implicit in these charges is the collection of an international committee of scientists to "investigate" the evidence, on the pretext that the International Red Cross Committee and the World Health Organization were incapable of conducting an unbiased inquiry in the field. What the Chinese "scientists" needed, in reality, was a commission that would confine itself to looking at the prepared documents and not go prying about in the field asking embarrassing questions about direct evidence.

One member of the commission, Joseph Needham of England, has recently publicly admitted that the commission made no objective investigation whatever of the basic evidence, but merely listened to, and believed, what their Chinese hosts told them. If the reports were honest, and based on fact, no such carefully contrived mock "investigation" would have been needed; either the Red Cross or the WHO would have confirmed the charges as drawn. It is obvious, on the face of it, that the Chinese were afraid to permit any such investigation; and the only possible basis for such fear is that the reports were fabrications and lies, from first to last.

# THIS IS WHAT'S NEW!

Weiser, Spiotta and Ekman treated fifty cases of **amebiasis,** found that 48% of patients continued to have E. histolytica trophozoites and cysts after combined **terramycin** and **chloroquine** therapy. In a smaller group of patients treated with aureomycin, the results were about as poor. They conclude that the antibiotics are apparently no better in the intestinal form of the disease than the older forms of therapy—carbarsone, diodoquin, emetine, and chloroquine, or combinations thereof. However, no mention is made of their dose or the duration of treatment. (*Ann. Int. Med.* 38:1002-1026 [May] 1953.)

Kinsell, Partridge and Foreman in a preliminary report on nine patients with **thyrotropic exophthalmos** treated with **ACTH and cortisone** over the past two years conclude that these drugs appear to "favorably modify" this disturbing complication of hyperthyroidism. They guess that the mode of action may be by lysis of abnormal deposits within the E.O.M. or by inhibiting the production of thyrotropin. This work may be worthy of more than passing notice in that it was carried out and reported in the same area in which the orbital decompression operation was developed by Dr. Naffziger. (Ibid. 913-917.)

Wolfson *et al.* find ACTX-HG (**High potency corticotropin** obtained by chromatographic fractionation) 3x's as effective per unit dose as ACTH-HG — Why? ACTX "probably undergoes less extravascular inactivation than ACTH." "ACTX" is marketed as HP Acthar Gel (Armour) and as Purified Corticotropin Gel (Wilson). (*Am. J. Med.* 14:534 [April] 1953.)

**Ligation** of the **hepatic** and **splenic arteries** for bleeding gastro-esophageal varices associated with Laennec's cirrhosis has been advocated recently. However, Witter and First after performing the above procedures on a patient with ascites wonder "why there should have been esophageal bleeding in a patient who had none previously, especially immediately following an operation designed to avoid it!" Exclamation mark theirs. The patient had a fatal hemorrhage from varices post operatively. *Surgery* 33:663-672 [May] 1953.

**Phenylbutazone** (Butazolidin), chemically similar to aminopyrine, and, like aspirin, good for joint pains, appears to be not so good for the hematologic and G.I. systems. In the JAMA Clinical Notes Feb. 14 and May 2, '53 there are a number of reports of **agranulocytosis** including fatal cases. Also associated with the use of this drug—gastric complications are described including appearance of multiple **gastric ulcers,** gastric ulcer with hemorrhage and duodenal ulcer.

In the *Journal of Thoracic Surgery* (25:234-245 [March] '53), Peck *et al.* review their first 56 **bronchograms** obtained by using a **water soluble** compound (50% Diodrast in 1.75% Methylcellulose). Results: 1. Two anaphylactoid deaths. 2. One third of bronchograms unsatisfactory. Conclusion: "They (i.e. water soluble compounds) cannot, however, be considered the ideal agent for bronchography."

**Doctors** are no more alert to their own symptoms of undiagnosed **cancer** than their patients. Robbins, MacDonald and Pack found that 39.8% of a group of physicians were responsible for a delay in their own diagnosis or treatment (waited 3 months after symptoms started before doing anything about it or refused advice to have necessary biopsy, x-ray, etc. performed). Of laymen, 39.5% fell into this same group. (*Cancer* 6:624-626 [May] 1953.)

**"The Fertile Eunuchs"** Syndrome is described by McCullagh, Beck and Schoffenburg (in *J. Clin. Endocrin. and Metab.* 13:489-509 [May] '53). Normal urinary F.S.H. and low or normal I.C.S.H. with the clinical picture of eunuchoidism. The response to **chorionic gonadotropin** was "satisfactory in three cases and striking in two."

S. Bessman, at the Am. Acad. of Ped. meeting, notes that **Versene** (Calcium disodium ethylenediaminetetraacetic acid) is effective in the treatment of **lead encephalopathy.** The tissue lead replaces the calcium in the complex forming lead versenate, a non toxic compound which is excreted in the urine. (Milnor, J., *Proc. Staff Meet. Straub Clinic* [July] 1953.)

Various EDTA compounds have found wide use in industry in the removal of metal ions from solutions. The early reports would seem to indicate that the versenes are more effective than BAL in treatment of metal poisoning. Perhaps this is the most suitable chaser (IV) for Gator Roach Hive.

FRED I. GILBERT, JR.

# BOOK REVIEWS

## Physical Medicine and Rehabilitation for the Aged.

By Walter S. McClellan, M.D., 81 pp., Price $2.00, Charles C. Thomas, 1951.

A pamphlet of sixty-four pages written by the Medical Director of the Saratoga Spa discusses very briefly the subject in nine chapters. It has a good bibliography and is well indexed.

As the title indicates, it covers the treatment of abnormal symptoms in the aging, including the psychoses. Its importance is emphasized by the fact that by the year 2000, two-fifths of the population will be over forty-five years of age, while in 1900 only one-fifth were.

A first aid discussion of the treatment of traumatic conditions is gone into, it is felt, to unnecessary length, in a short monograph of this nature. This includes bruises and contusions, strains, sprains and even the more serious, such as fractures and dislocations. Low back pain is discussed in two short paragraphs.

Occupational therapy is well handled in three short paragraphs in Chapter 8 and in his concluding statement in the last chapter he aptly states that "Rehabilitation in the aged is a challenge to all physicians as well as the communities who are concerned with the place to be filled by older individuals."

The book is well bound for a pamphlet and is well worth reading by everybody, including the layman, for whom it apparently was largely intended—reading time, 15 minutes.

J. Warren White, M.D.

## Rheumatic Diseases.

By Eugene F. Traut, M.D., F.A.C.P., 942 pp. with 192 illustrations, Price $20.00, C. V. Mosby Company, 1952.

In 1944, B. L. Comroe published 1359 pages on "Arthritis and Allied Conditions." The real addition in the present volume is 57 pages (6%) devoted to discussion of the endocrines in arthritis as compared with 19 pages (1.3%) in '44. However, even this chapter seems already outdated, since Traut says "failures in severe cases given 'adequate' dosage (of cortisone, etc.) may exceed 15%." The recent evidence we have suggests that probably not more than 5% continue to do well on the new hormones. In '44, 41 pages were devoted to gold therapy, whereas Traut dismisses the subject in less than 6. His chapter on focal infection seems a reflection in the Rosenow direction, although he admits "in general, enthusiasm for eradication of infectious foci has waned." Forty-two pages are given over to gout, 101 pages to rheumatic fever, and 84 pages to rheumatic diseases of the back including disorders of the intervertebral disks. This seems to be in keeping with this day of much backache.

It is a good review, but for the sake of our overburdened book shelves, I believe authors should limit themselves to the completely new, at least until an enormous previous volume has gathered some dust. It would help our tired eyes.

Nils P. Larsen, M.D.

## Treatment of Mental Disorder.

By Leo Alexander, M.D., 507 pp., illustrated, Price $10.00, W. B. Saunders Company, 1953.

Dr. Alexander has written this book from a background of long clinical experience, broad training and a bibliography of several hundred references. His aim is to integrate the physiological and psychological viewpoints toward mental disease and its treatment. This aim, of course, is an extremely ambitious one and the attempt to meet it has made for some difficulty in following the development of the theses through this book. His secondary goal of presenting in great detail a variety of useful physical treatment techniques is definitely accomplished. There are sections on treatment results and complications which are hard to find in any other book. The author uses his personal experience and favorite treatment techniques frequently throughout the book; however, one feels that this adds to rather than detracts from the readability. This book should be a part of the library of every psychiatrist and will be most useful in psychiatric hospitals. The sections on psychotherapy are brief but well written.

Robert A. Kimmich, M.D.

## Stress and Disease.

By Harold G. Wolff, M.D., 199 pp., Price $5.50, Charles C. Thomas, 1953.

Sticks and stones may break my bones,
And names can hurt me too.
—*Revised Nursery Rhyme*

The practical importance of emotional factors in the production of disease is concisely and convincingly presented in this, the 166th monograph in Thomas's American Lecture Series. The stress concept as developed by Claude Bernard, Cannon and Selye is brought right to the bedside and into the consulting room in clear, forthright language.

This is a book to convince the skeptic, broaden and deepen the understanding of the True Believer, and improve the quality of practice of almost any physician willing to read it. It is especially recommended for general practitioners, allergists, internists and pediatricians—but no-one could fail to profit by it.

*Mirabile dictu*, the word "psychosomatic" wasn't encountered anywhere in the text, and does not appear in the index!

Harry L. Arnold, Jr., M.D.

## P-Q-R-S-T—A Guide to Electrocardiogram Interpretation.

By Joseph E. F. Riseman, M.D., Third Edition, 123 pp., Price $4.00, The MacMillan Company, 1952.

Here is a useful booklet for the beginner in the interpretation of electrocardiographic tracings. It is a compact, pocketsize edition, arranged so as to facilitate the analysis of any tracing in order to arrive at a diagnosis. It is meant not to replace standard textbooks on electrocardiography but rather to supplement them.

Albert H. Ishii, M.D.

### Standard Values in Blood.

Edited by Errett C. Albritton, A.B., M.D., 199 pp., Price $4.50, W. B. Saunders Company, 1952.

This book is a compilation of standard values of various constituents of the blood. It lists values for various animal species. The book also records different results by different methods and investigations for the same species. Values are all listed in charts or graphs. The references are extensive. Numerous contributors and reviewers are cited. Some theories are charted.

The book has a stiff paper binding. The print, although small in places, is clear and legible.

The volume appears to be of value as a reference for scientific research and for evaluation of subjects covered. It can be of use in a university or medical library as a reference book.

W. Harold Civin, M.D.

### Ocular Therapeutics.

By William J. Harrison, M.D., Phar.D., F.A.C.S., Second Edition, 282 pp., Price $5.00, Charles C. Thomas, 1953.

This pocket size handbook should have been labeled ocular pharmacology rather than ocular therapeutics.

Approximately half of its 267 pages are taken up with a concise account of the description, origin, physical properties, pharmacologic action and incompatibilities of the common and generally accepted drugs used in ocular therapeutics.

The book contains no new ideas for the clinical ophthalmologist. It holds a certain appeal to interns, residents, general practitioners, and plantation physicians who may occasionally be called upon to treat simple eye diseases. It should also serve as a valuable reference in medico-legal problems involving the use of drugs and should be of considerable interest to pharmacists and biochemists.

William John Holmes, M.D.

### How to be Healthy in Hot Climates.

By Eleanor T. Calverley, M.D., Second Edition, 286 pp., Price $3.50, Thomas Y. Crowell Company, 1953.

The author is attempting to tell the prospective missionaries and travelers how to live in the tropics. Her materials are excellent, but are too technical from the layman's viewpoint. Young's rule for dosages should be left to physicians and nurses. Explanations of various tropical diseases would tend to confuse the average missionary.

The maps portraying the areas of prevalent diseases are rather misleading and confusing. The Hawaiian Islands seem to harbor all of the tropical diseases mentioned.

There are too many references for the reader to wade through before one is able to perform first-aid in case of emergency. If this book is to help the traveler in the tropics, I believe the author should have written specific treatments for emergencies, instead of referring to other sources.

In certain instances the author recommends treatments which should be given by physicians. Furthermore, "one must carry a drug store along while traveling in the tropics," is the impression given in this book.

All in all, this is a good book for a class or missionaries preparing for a sojourn in the tropics.

James T. Kuninobu, M.D.

### Psychiatric Aide Education.

By Bernard H. Hall, M.D., Mary Gangemi, R.N., Litt.M., V. L. Norris, A.B., Vivienne Hutchens Vail, A.B., P.A., and Gordon Sawatsky, A.B., P.A., 168 pp., Price $5.75, Grune & Stratton, Inc., 1952.

This book is the report of the program of psychiatric aide education conducted at the Topeka State Hospital by The Menninger Foundation in Topeka, Kansas. The program evolved because of an outstanding need for competent personnel to provide nursing care for the hospitalized mental patients.

If, as the personnel making the study believe, the activities of the attendant and psychiatric aide group prove to be nursing activities, it will be incumbent upon the nursing profession to assume the primary responsibility for preparing this worker for this job. A course outline has been prepared, teaching methods briefed, and reference material which offer a valuable contribution in this field.

O. Dorothy Benson, R.N.

### Clinical Diagnosis by Laboratory Methods.

By James Campbell Todd, Ph.B., M.D., Arthur Hawley Sanford, A.M., M.D., and Benjamin B. Wells, M.D., Ph.D., Twelfth Edition, 998 pp., illustrated, Price $8.50, W. B. Saunders Company, 1953.

This book is claimed to be a working manual of clinical pathology and attempts to be just that. Dr. Benjamin B. Wells, Professor of Medicine at the University of Arkansas, is a new collaborator.

The authors have not made drastic alterations from the eleventh edition, although some changes have been made in the chapters on urine analysis and bacteriology. There are additions to the chapter on hematology and to the one on the serologic tests for syphilis. Furthermore, this latter is made to conform with techniques published in Supplement Number 22, Journal of Venereal Disease Information, U. S. Public Health Service.

As always the book is well written and illustrated. Not all laboratory methods are listed, but rather the commoner or more practical ones. There is always an attempt to establish norms and to correlate results with disease conditions. The index-outline of laboratory findings in important diseases is maintained. The entire field of clinical pathology is covered.

The book has a cloth binding and is sturdy. The print is legible. The illustrations are clear. Charts and diagrams are well utilized.

W. Harold Civin, M.D.

### Neurosurgery in General Practice.

By Adrien Ver Brugghen, M.B., Ch.M., M.S., F.A.C.S., 665 pp., Price $14.00, Charles C. Thomas, 1952.

This book is very readable, well illustrated, brief in its description of neurosurgical entities, and down to earth in its discussions of neurosurgical problems. Each disease entity is described clearly and well illustrated, not only with pictures but also with actual case histories. The text describes for the clinician what diagnostic procedures to use, what results one may hope to demonstrate, what neurosurgical procedure may be used once a diagnosis is established, and what to tell the relatives regarding surgical risks and prognosis. All in all this is a very practical book and I recommend it highly.

Robert C. H. Chung, M.D.

### Tuberculosis.

By Saul Solomon, M.D., 310 pp., Price $3.50, Coward-McCann, Inc., 1952.

This book is intended for the lay reader rather than the physician. It presents tuberculosis in an orderly fashion, starting with a discussion of cause and history, and proceeding through primary and reinfection tuberculosis to treatment. The author has succeeded admirably in presenting a large amount of data in nontechnical language. The chapters on treatment methods and principles are especially well done and up to date. This book can be recommended to members of the public who are seriously interested in tuberculosis. It also would serve as an excellent introduction to nursing students.

KENNETH W. MOMEYER, M.D.

### A Manual of Clinical Allergy.

By John M. Sheldon, M.D., Robert G. Lovel, M.D., and Kenneth P. Mathews, M.D., 413 pp., illustrated, Price $8.50, W. B. Saunders Company, 1953.

This relatively small book on allergy has a number of things to be commended. It is replete with the minutiae of many phases of practice dealing with allergy. The general practitioner and the man in a number of specialties should find it useful in the diagnosis and management of allergic problems. The specialist handling allergic diseases will find certain sections of the book such as those dealing with patch-testing and the identification of aeroallergens somewhat more extensively handled than in the ordinary text.

The authors state that their book is to be used in conjunction with standard texts and periodicals. In this sense, it can be recommended. On the other hand, it does not provide enough of certain information to be the sole book on allergy on the student or general physician's shelf. I believe that even in a manual of this nature, more of the fundamental principles of allergy should be discussed.

In any book in which there is an attempt to provide an infinite number of small details, it is obvious that many equally important small matters must be omitted. For example, minor details of office furnishings are provided including even the number and nature of waiting room chairs. Unfortunately, some essential items are omitted. Similarly the sources of many proprietary medicines are given but those of others are omitted. Most of the book is written in language that flows; however, there is an over-abundance of footnotes. Many of these notes distract from the ease of reading, and a number of them might well be incorporated in the text.

This book is recommended without reservation as adjunct material in the field of allergy.

SAMUEL D. ALLISON, M.D.

### B-Vitamins for Blood Formation.

By Thomas H. Jukes, Ph.D., 113 pp., Price $4.00, Charles C. Thomas, 1952.

As a monograph this text is acceptable. As a source book for practical clinical information it is not second to none. I recommend this book to one who is doing investigative work in this field, or to someone who has three hours he would like to invest to increase his "store of knowledge."

ROBERT C. H. CHUNG, M.D.

### Diseases of the Esophagus.

By Philip Thorek, M.D., F.A.C.S., F.I.C.S., 140 pp., illustrated, Price $10.00, J. B. Lippincott Company, 1953.

This new monograph offers a thorough and systematic description of the anatomy, physiology, diagnosis, and medical and surgical treatment of the esophagus and its diseases. It is abundantly illustrated with outstanding line drawings by Mr. Carl T. Linden, which add greatly to the clarity and value of the entire volume.

Dr. Thorek's style of writing is facile and informative. He offers a number of phrases which make for a better understanding of his subject and which may be quoted easily in teaching—such as "change in swallowing habits" (which term I have not heard applied to this end of gastro-intestinal tract), or his use of the letter "C" for remembering the symptoms of congenital tracheo-esophageal fistula ("C standing for Cold — which new born babies rarely have—Chokes, Coughs and becomes Cyanotic").

His bibliography is complete, but he did not use an adequate numerical cross reference to it in his text. Also he did not quote his authors completely (e.g. on page 94—"Clagett reported an average weight loss . . . etc" —but the authors were actually Clagett and Wiig).

The price of $10.00 seems high considering the size of the volume—140 pages. However, I recommend highly a perusal of this book by all physicians who see patients with symptoms referable to the upper gastrointestinal tract.

LAURENCE M. WIIG, M.D.

### Post-Graduate Lectures on Orthopedic Diagnosis and Indications.

By Arthur Steindler, M.D., F.A.C.S., Volume IV, 318 pp. with 338 illustrations, Price $9.75, Charles C. Thomas, 1952.

This is the fourth volume edited by the same author under the same title. In this volume the author covers rather adequately two large fields of orthopedics: (1) arthritis and diseases of muscles, bursae, tendons and fasciae and (2) deficiency and degenerative diseases of the locomotor system.

These "lectures" are presented in such a manner as to familiarize the reader with fundamentals upon which he can build a sound rationale for management and treatment. The section on arthritis, dealing with both atrophic and hypertrophic arthritis, is very well done and up-to-date.

This book furnishes an excellent review and reference for the busy physician and is recommended for all who are concerned with the subjects covered in this book.

B. ALLEN RICHARDSON, M.D.

### Familial Nonreagenic Food Allergy.

By Arthur R. Coca, M.D., Third Edition, 279 pp., illustrated, Price $10.50, Charles C. Thomas, 1953.

This book presents an intriguing theory with regard to a type of allergy fairly well described in the title. Some of the common symptoms of this condition are: hives, headache, heartburn, indigestion, constipation, canker sores in mouth, dizziness, neuralgia, abnormal tiredness, chronic rhinitis and asthma.

Most of this edition is devoted to explaining the

pulse-rate method of diagnosing the etiologic factors in this condition. The basic theory, as presented, is that there is an increase in pulse rate following the ingestion of the food or chemicals causing the symptoms. It is not quite so simple as it sounds, and considerable time and experience are needed to carry out a satisfactory study.

I have had no personal experience with this method of diagnosis. However, Dr. Coca is a pioneer in the field of allergy and his opinions deserve careful consideration and study.

W. A. MYERS, M.D.

### Patterns of Survival.

By John Hodgdon Bradley, 223 pp., Price $3.75, Grune & Stratton, Inc., 1953.

A paleontologist examines the history of life from prehistoric times down to the present and concludes that man, though maladjusted (in comparison with other organisms) to his environment, still has an excellent chance to survive, and even to overcome confusion.

Terse and amusing, but also thoughtful and scientifically sound, this book should prove as entertaining and profitable to the layman as to the scientist.

SIDNEY L. HALPERIN, PH.D.

### The Roentgen Aspects of the Papilla and Ampulla of Vater.

By Maxwell H. Poppel, M.D., F.A.C.R., Harold G. Jacobson, M.D., F.A.C.R., and Robert W. Smith, M.D., 195 pp., illustrated, Price $8.50, Charles C. Thomas, 1953.

The roentgenological appearance of the normal papilla and ampulla of Vater is well described and documented. Painstaking care and effort have entered into the author's investigations. The variable anatomy of the vaterian area is shown, much for the first time. Also it is proved that the papilla can be radiographically demonstrated in 50% of normal individuals. Many delightful facts of new information are brought out. It is most unfortunate that these "pearls" of information are buried in a verbose, repetitious, poorly written monograph. If the writing were condensed to thirty pages it would be excellent. As written, only a few will ever wade through all of the sections in the text. Despite that, it is highly recommended that the radiologist, at least, thumb through the book and read chapter 9.

GEORGE W. HENRY, M.D.

### The Temporomandibular Joint.

By Bernard G. Sarnat, M.D., M.S., D.D.S., F.A.C.S., 165 pp. with 62 illustrations, Price $4.75, Charles C. Thomas, 1951.

This is a monograph which serves well for critical evaluation of the literature and further study of the temporomandibular joint, together with its anatomy and the anatomy and functions of the muscles of mastication. It also describes the joint's functions and the muscles involved in its various movements. There are also three chapters devoted to histology and development.

The second half of this interesting text concerns pathology and diagnosis of abnormal conditions. The last chapter deals with diagnosis and dental treatment of several illustrated case histories.

PERCY H. WILSON, D.D.S.

## Also Received

### Hypersplenism.

By Cyrus C. Sturgis, M.D., 97 pp., Price $3.25, Charles C. Thomas, 1953.

Clear, concise and complete analysis of hypersplenism by a topnotch hematologist and clinician.

### The Founders of Neurology.

Edited by Webb Haymaker, M.D., 479 pp., Price $10.00, Charles C. Thomas, 1953.

Photographs and capsule biographies of neuroanatomists and neurophysiologists, neuropathologists, clinical neurologists and (7) neurosurgeons and references to their publications.

### The Conception of Disease, Its History, Its Versions and Its Natures.

By Walter Riese, M.D., 120 pp., Price $4.75, Philosophical Library, 1953.

Very heavy going. It might be worthwhile for a philosopher.

### Physical Examination of the Surgical Patient.

By J. Englebert Dunphy, M.D., F.A.C.S. and Thomas W. Botsford, M.D., F.A.C.S., 326 pp., illustrated, Price $7.50, W. B. Saunders Company, 1953.

Aimed mainly at medical students.

### Sacral Nerve-Root Cysts.

By I. M. Tarlov, M.D., 134 pp., illustrated, Price $6.50, Charles C. Thomas, 1953.

All about the occasional causes of the sciatic or cauda equina syndrome.

### The Medical Clinics of North America.

Nationwide Number, March, 1953—Nervous and Mental Diseases, pp. 295-627, figs. 33-86, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1953.

### The Grassi Block Substitution Test for Measuring Organic Brain Pathology.

By Joseph R. Grassi, A.B., M.S., 75 pp., Price $3.00, Charles C. Thomas, 1953.

Building blocks and psychiatry integrated.

### Children of Divorce.

By J. Louise Despert, M.D., 282 pp., Price $3.50, Doubleday & Company, Inc., 1953.

An understanding book on an often misunderstood problem.

### Hypersplenism and Surgery of the Spleen.

By William Dameshek, M.D. and C. Stuart Welch, M.D., 84 pp., illustrated, Price $10.00, Grune & Stratton, Inc., 1953.

Authoritative, complete and instructive; a scientific exhibit in book form.

### The Surgical Clinics of North America.

New York Number, April, 1953—The Surgery of Cancer, pp. 311-617, figs. 36-138, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1953.

### Current Problems in Psychiatric Diagnosis.

Edited by Paul H. Hoch, M.D. and Joseph Zubin, Ph.D., 291 pp., Price $5.50, Grune & Stratton, Inc., 1953.

### The Epidemiology of Health.

Edited by Iago Galdston, M.D., 197 pp., Price $4.00, Health Education Council, 1953.

# HMSA—Its Place in the Community

## Objectives for 1953

J. R. VELTMANN, *General Manager*

HMSA points with pride to the fact that its membership has grown one hundred times since its inception in 1938. This growth indicates, without question, that HMSA has proven its value as a community service. As a result of favorable operations in 1952, the Association has incorporated additional benefits without increasing monthly premiums to members.

Our sights for 1953 have been set high and every effort is being utilized to promulgate the value of a prepayment voluntary health plan as a means to meet increasing costs of medical and hospital care today. Our first major project was a Community Enrollment drive held in conjunction with the 49th State Fair from the period June 19 to July 20, 1953. At that time, HMSA accepted individuals and their dependents, who do not qualify for enrollment through employed groups, for coverage under the Surgical-Hospital-Maternity plan. It was most gratifying for the Association to receive full support and assistance from all Participating Physicians and hospitals to circulate literature and application forms to patients who did not enjoy medical protection. Newspaper advertising and posters were used as additional means to inform the public of this special enrollment. This drive stimulated a great public interest in the necessity to budget for the day when misfortune strikes, and unforeseen medical and hospital bills are incurred. As a result of this drive, HMSA enrolled not only individuals and their dependents, but many employed groups who were not aware of our service.

It is our aim to improve our basic plan in 1953. We have accumulated and analyzed certain suggestions and complaints received from doctors, hospitals and members in the course of our daily administration of the plan, and with these as a guide, we plan to reduce certain waiting periods to permit members to apply for services at the earliest possible date after enrollment and to eliminate some of the features and restrictions which have caused misunderstandings or are difficult to administer. Informative reports and bulletins will be used as a means to keep all of our participants apprised of the growth and progress of the Association.

Careful scrutiny of the internal functions of HMSA will continue and more efficient procedures will be developed for the operations of each department in an effort to keep administrative operating costs to a minimum. Improvements and increased membership in the past two years have helped to reduce operating costs by three percent.

Today the people of Hawaii have become aware of the importance of health protection. Employers and unions representing large numbers of employees have incorporated medical plans as a part of their negotiations in contractual relations. This social change has brought about demands for more extensive medical coverage and to meet this demand by the public, and to keep abreast of the latest trends in medical care, HMSA is developing an EXTENDED BENEFITS PLAN which it hopes some day will be available to the entire community. In the meantime, the plan is conducting experiments in order to develop sound statistical and actuarial data on benefits which have not been previously included for coverage.

HMSA is planning today for a healthier tomorrow for the people of Hawaii.

# Territorial Association Report

## REPORT ON HOUSE OF DELEGATES AMERICAN MEDICAL ASSOCIATION

The House of Delegates of the American Medical Association, in session at the Waldorf-Astoria Hotel during the 102nd Annual Meeting of the A.M.A. in New York City, June 1-5, 1953, took important policy actions on veterans' medical care, medical ethics, osteopathy, intern training and a wide variety of subjects ranging from medical education to public relations.

The House also named Dr. Walter B. Martin of Norfolk, Virginia, as president-elect of the American Medical Association for the coming year. Dr. Martin will become president at the June, 1954 meeting in San Francisco, succeeding Dr. Edward J. McCormick of Toledo, Ohio, who took office at a special inaugural session of the House of Delegates in the Hotel Commodore during the New York meeting.

Giving unanimous approval to a recommendation from its Reference Committee on Insurance and Medical Service, submitted as a substitute for eight different resolutions concerning the treatment of non-service-connected disabilities by the Veterans Administration, the House adopted the policy that such treatment should be discontinued except in cases involving tuberculosis or psychiatric or neurological disorders.

Eleven resolutions dealing with publicity regarding unethical conduct of physicians were brought before the House as a result of recent newspaper and magazine articles reporting statements attributed to an official spokesman of an allied medical organization. (L'affaire Hawley—ed.) The House adopted a committee report which recommended no action on the eleven resolutions but which reaffirmed the supremacy of the A.M.A. code of ethics and urged that the Judicial Council study suggested revisions concerning methods of billing. The report in part stated:

"Broad generalizations, ill-advised and poorly prepared statements that often fail to convey the intended meaning are most unfortunate and are to be deplored. Destructive critical comments serve no useful purpose. Your committee has the utmost confidence that the great majority of our members are entirely capable of avoiding these pitfalls without additional advice from this committee."

Most controversial issue brought before the House at the New York meeting proved to be the question of immediate or deferred action on the report of the Committee for the Study of Relations Between Osteopathy and Medicine. The House, after two hours of vigorous, spirited debate, adopted the majority report of the Reference Committee on Miscellaneous Business, thereby postponing action until the June, 1954, meeting and allowing further study by the delegates and the state associations.

A recommendation of the Committee for the Study of Relations Between Osteopathy and Medicine follows:

"That the House of Delegates declare that so little of the original concept of osteopathy remains that it does not classify medicine as currently taught in schools of osteopathy as the teaching of 'cultist' healing."

The following recommendation by the Board of Trustees was approved:

"Because of the length of the report and the controversial nature of the subject, the Board feels that the House should have adequate time for its study and that the state associations should have opportunity to express their opinions.

"Therefore, it is recommended that the Committee be continued but that action on the report be deferred until the June, 1954, session. It is suggested that at that time the House be prepared to answer the following questions:

"1. Should modern osteopathy be classified as 'cultist' healing?

"2. Since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?

"3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?"

Highlights of the opening day session of the House were addresses by Dr. Louis H. Bauer, who delivered his term-end report as retiring president; Dr. Edward J. McCormick, who spoke on that day as president-elect; and Mrs. Oveta Culp Hobby, United States Secretary of Health, Education and Welfare; and selection of the winner of the 1953 Distinguished Service Award.

Dr. Bauer, referring to charges of unethical practices among some doctors, declared that all members of the medical profession "should not be tarred with the same stick."

Dr. McCormick outlined a nine-point program for further improvement in the nation's medical care and expressed the hope that "their further development will solve many of medicine's problems and eliminate much of the criticism to which we are subjected.

Mrs. Hobby told the delegates that the present administration in Washington is looking with confidence to the nation's physicians for leadership in meeting the challenge of modern medical care problems.

The 1953 Distinguished Service Award was voted to Dr. Alfred Blalock of Baltimore for his outstanding work in vascular surgery and his part in the development of the so-called "blue baby" operation.

In addition to the selection of Dr. Martin as president-elect, the House also elected Dr. Carl H. Gellenthien of Valmora, New Mexico, to the office of vice president. He succeeds Dr. Leo F. Schiff of Plattsburgh, New York.

Re-elected to office were:

Dr. George F. Lull, Chicago, secretary and general manager; Dr. J. J. Moore, Chicago, treasurer; Dr. James R. Reuling, Bayside, New York, speaker of the House of Delegates; Dr. E. Vincent Askey, Los Angeles, vice speaker of the House; Dr. Edwin S. Hamilton, Kankakee, Illinois, and Dr. Gunnar Gundersen, LaCrosse, Wisconsin, as members of the Board of Trustees.

The House elected Dr. Julian P. Price of Florence, South Carolina, to fill Dr. Martin's unexpired term on the Board of Trustees.

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The regular meeting of the Hawaii County Medical Society was held on April 23, 1953 at the Hilo Memorial Hospital. Meeting was called to order by President Hayashi at 8:00 p.m. Present were Doctors M. H. Chang, Hayashi, Henderson, Kasamoto, Loo, Matayoshi, Mitchell, Okumoto, Orenstein, Ota, Stemmermann, Steuermann, Tomoguchi, Woo, Yamanoha, and Yuen. Guests present were: Mr. J. R. Veltmann, Mr. James Carroll, Mr. Jack Hall, Mr. William Chang, and Mr. Fred Low, Jr.

Mr. Veltmann of the Hawaii Medical Service Association gave an account of HMSA operation for the year 1952, which proved to be highly satisfactory.

Mr. Jack Hall explained the operation of the newly negotiated ILWU Longshoremen's medical plan. Mr. Hall was assisted by Mr. William Chang and Mr. Fred Low, Jr.

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The regular meeting of the Hawaii County Medical Society was held on Thursday, May 28, 1953, at the Hilo Memorial staff room. In the absence of President Hayashi and President-elect Dr. Kutsunai, the meeting was called to order by the secretary. Present at the meeting were: Doctors Bergin, M. H. Chang, M. L. Chang, Higa, Kasamoto, Kaufmann, Mitchel, Miyamoto, Okumoto, Orenstein, Ota, Steuermann, Tomoguchi, Woo, and Richard Yamanoha. Guests present were: Doctors Victor V. Donahey, Frank Palacio, and A. Hicking.

After a lengthy discussion, it was moved by Dr. Pete Okumoto and seconded by Dr. M. H. Chang that the Hawaii County Medical Society go on record to accept the withholding of nine per cent (9%) from all HMSA claims available for payment in June of this year up to and including claims paid in May 1954. Motion was passed unanimously.

During the month of May, the Hawaii County Medical Society lost two of its members of outstanding abilities. Dr. Walter James Seymour passed away after a short illness in the Kona Hospital on May 21, 1953. Dr. Clyde Lincoln Phillips, who has been in ill health for the past two years, died quietly at the Hilo Memorial Hospital on May 26, 1953.

NICHOLAS STEUERMANN
*Secretary*

## HONOLULU COUNTY MEDICAL SOCIETY

On the evening of May 11, 1953 in the Mabel Smyth Auditorium, a special membership meeting was called to consider House Bill No. 692 (relating to Workmen's Compensation)* and a newly conceived health plan of HMSA whereby the members of the Honolulu County Medical Society would underwrite the plan by agreeing to HMSA's withholding 9% on all claims. Dr. Ito presided, with approximately 120 members present.

A vigorous pro and con discussion followed during which many felt that a free choice of physician was the major issue. There was also considerable feeling that legislative action would not provide a satisfactory solution and that any change in the Workmen's Compensation Law should be further studied in view of the bill's potential effect on plantation medicine.

A motion to liberalize the plan but oppose the bill was defeated 49 to 38, and a subsequent motion to approve the bill and urge its passage through the Senate passed with 49 in favor and 41 opposed.

To compete successfully with commercial carriers, HMSA feels it must offer the HRT Company a plan which includes the first office visit. Having no actuarial experience in respect to the first office visit, HMSA feels the medical profession (participating physicians) should underwrite the plan by agreeing to a 9% withholding by HMSA on claims of all members in order to establish an additional cash reserve.

At a special meeting on May 5 the Board of Governors approved HMSA's new plan for the HRT Company and agreed to the 9% withholding provided the latter applied only to claims of HRT Company members.

By motion duly made and carried, the Society authorized HMSA to withhold 10% on all claims for a period of one year, said withholding to defray any deficit on any group that was offered benefits in a plan for which HMSA has no previous experience.

There being no further business the meeting adjourned at 10:45 p.m.

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A regular meeting of the Honolulu County Medical Society was held in the Mabel Smyth Auditorium June 5, 1953 at 8:00 P.M. with Dr. William S. Ito presiding and approximately 85 members and guests present.

Mr. E. E. Black gave a progress report on the development of the new surgical wing for Queen's Hospital and appealed to the doctors for substantial financial support.

Mr. E. Ehlke discussed a new drug, Nisentil.

Mr. Scott B. Brainard described the Pineapple Companies' medical plan recently developed by company and union representatives for regular and intermittent employees.

Dr. Rudolf Schindler, Associate Professor of Internal Medicine at the College of Medical Evangelists in Loma Linda, discussed the "Clinical Significance of Gastroscopy." Dr. C. M. Burgess commented on Dr. Schindler's paper.

Dr. Ito stated that it was the recommendation of the Auditor that the Society's $6,000 in Series "D" bonds now matured be liquidated and the proceeds reinvested unless the Society has planned for other use of the funds. Concurrently the Board of Governors recommended that the proceeds be made available to the Public Service Committee.

* See editorial in this issue.

Dr. C. C. McCorriston, Public Service Committee Chairman, stated that it has been the Society's objective for some time to hire an expert public relations counsel or executive secretary. The Committee also favored the formation of a collection and credit bureau to support this program. It was pointed out that the Maricopa County Medical Society in Arizona, with a similar number of physicians, has successfully operated its own collection and credit bureau for some time. Dr. McCorriston informed the membership that capital would be needed to initiate the program and estimated that it would take approximately two years before the bureau would be financially independent.

Since the Society had gone on record approving the recommendations of the Public Service Committee, Dr. Ito entertained a motion regarding the bonds. On motion of Dr. R. Millard duly seconded and carried, the Society voted that the $6,000 in Series "D" bonds be made available to the Public Service Committee.

The Society also voted to dispense with the July and August membership meetings.

There being no further business, the meeting adjourned at 10:00 P.M. to refreshments on the lanai.

R. C. DURANT, M.D.
*Secretary*

## KAUAI COUNTY MEDICAL SOCIETY

A special meeting of the Kauai County Medical Society was held on April 6, 1953 in the G. N. Wilcox Hospital Library. Dr. Clyde Ishii, President, called the meeting to order at 7:30 p.m. Other members present were Drs. Wallis, Cockett, Kuhns, Masunaga, Goodhue, Brennecke, Fujii, and Yamauchi. Guests were Dr. Sykes, Dr. R. Faus, Mr. Albert Yuen, and Mrs. Inouye.

After a brief business session, the meeting was turned over to Dr. Faus and Mr. Albert Yuen. Dr. Faus pointed out the necessity for the HMSA to submit its medical plan in bidding for the Pineapple Industry medical contract. Mr. Yuen reviewed the proposed HMSA medical plan. After a lengthy discussion relative to benefits, procedures, administration, and costs, Dr. Wallis made the motion that the Kauai County Medical Society go on record as willing to underwrite an HMSA plan for the Pineapple Industry and to further agree to a withholding to assure the successful operation of such plan. This motion was seconded and was unanimously approved.

In conclusion, Mr. Yuen presented a brief financial report of the HMSA.

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The regular meeting of the Kauai County Medical Society was held on April 14, 1953 at the G. N. Wilcox Hospital Library. Meeting was called to order by Dr. Clyde Ishii, President, at 7:45 p.m. Other members present were Drs. Kuhns, Wallis, Goodhue, Wade, Fujii, Cockett, Kemp, and Yamauchi. Guests were Dr. Sykes and Dr. Boudreau, resident.

Relative to Dr. Kemp's assumption of a new position in Honolulu in the near future, a motion to forward a letter to Dr. Richard Lee, President of the Territorial Board of Health, requesting that Dr. Kemp be permitted to visit Kauai periodically in order to continue her work as Public Health Officer until such time the position is permanently occupied, was made by Dr. Fujii. This was seconded and was passed unanimously.

A motion was made that the Society approve of the plan to have a HMSA booth at this year's Kauai County Fair. This was seconded and approved.

Dr. Sykes' application for membership was considered. Because of his imminent military service, it was decided to consider him as a non-paying member. His Society membership is pending the approval of the Board of Censors.

Dr. Kemp announced the receipt of new forms for the Fetal Death Survey from Dr. Yerushalmy. Some of the forms were exhibited.

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The regular meeting of the Kauai County Medical Society was held on May 5, 1953 at the G. N. Wilcox Medical Library. The meeting was called to order by Dr. Ishii, President, at 7:30 p.m. Other members present were Drs. Wallis, Kemp, Goodhue, Masunaga, Fujii, Wade, Cockett, Brennecke, Kim, and Yamauchi. Guests were Dr. Ian MacDonald, Dr. Sykes, and Dr. Boudreau.

Dr. Ishii read a communication from Dr. Richard K. C. Lee, President of the Territorial Board of Health, acknowledging the receipt of the letter requesting Dr. Kemp be permitted to visit Kauai periodically to continue her work here until the position of Kauai Public Health Officer is permanently occupied.

A motion to approve Dr. Sykes' application for membership was seconded and was unanimously passed.

The rest of the evening was devoted to Dr. MacDonald's lecture on "Uterine and Mammary Cancer."

RICHARD YAMAUCHI, M.D.
*Secretary-Treasurer*

## MAUI COUNTY MEDICAL SOCIETY

A joint dinner meeting of the Maui County Medical Society and the Auxiliary was held on May 13, 1953.

Those present were: Doctors and Mesdames Underwood, Kanda, Kashiwa, Izumi, Tofukuji, Rockett, Haywood, Patterson, Tompkins, Ferkany, Ohata and H. Kushi; Doctors Reppun, Rose, Burden, Mei; and Mesdames Sowers and Fleming.

Mr. D. W. Porter and Mr. Y. Yamane of the U.S. Life Insurance Company gave a short resume of the new Pineapple Medical Plan and invited questions from the Society.

Business being over, the meeting was turned over to Dr. Ralph Cloward who gave a most interesting talk on a recent safari in East Africa. The members enjoyed it thoroughly and thanked Dr. Cloward for his generosity in presenting the pictures.

H. KUSHI, M.D.
*Secretary*

# NOTES AND NEWS

## PERSONALS

**Dr. Alvin Majoska** was the winner for 1953 of a perpetual trophy for the annual long distance small boat yacht race.

**Dr. John Lynn** left for Los Angeles to attend the meeting of the American Psychiatric Association.

**Dr. and Mrs. Ogden Pinkerton** announce the birth of their fourth child, a boy, born on April 22, 1953.

**Dr. L. Clagett Beck** left in June for New York City to attend the meetings of the American Therapeutic Society.

Back in June from the annual meetings of the Industrial Medical Association held at Los Angeles were **Drs. Frank Hatlelid, William Wilkinson,** and **Nils P. Larsen.** Dr. Larsen also attended the meeting of the American College of Physicians in Atlantic City.

**Dr. and Mrs. Morton Berk** left in June for the meeting of the American Diabetic Association.

**Dr. James Wong** attended the International Congress of Sterility and Fertility held May 25-31 in New York City.

**Dr. and Mrs. Edwin Chung-Hoon, Dr. and Mrs. Howard Liljestrand, Dr. Homer Izumi, Dr. Alfred Hartwell, Dr. Rodney West, Dr. Raymond Yap, Dr. and Mrs. H. Q. Pang, Dr. H. B. Luke,** and **Dr. Burt Wade** attended the meetings of the American Medical Association in New York City.

Also off to the meetings of the American Medical Association, followed by a European jaunt, were **Dr. and Mrs. Walter Quisenberry.** Dr. Quisenberry participated in the British Medical Association meeting in Cardiff, Wales.

**Dr. and Mrs. William John Holmes** left for the mainland to attend meetings of the Pacific Coast Oto-Ophthalmological Society, the American Ophthalmological Society, the Association for Research in Ophthalmology and the American Medical Association.

**Dr. Hastings Walker** left in May to attend the Veterans Administration Conference in San Francisco and the National Tuberculosis Association meeting in Los Angeles.

**Dr. M. H. Mack** announces the removal of his office to Room 357 Young Hotel Building.

**Dr. and Mrs. Andrew Morgan** announce the birth of a son born on April 2, 1953.

**Dr. Raymond M. deHay** announces the opening of a downtown office for consultation by appointment in internal medicine and gastroenterology at Room 395 Young Hotel Building.

**Dr. Kyuro Okazaki** was elected a full Fellow, and **Dr. Albert Ishii** and **Dr. Fred Gilbert** were elected Associates of the American College of Physicians.

After a year of advanced study on the mainland, **Dr. Frank Glazer** will rejoin **Dr. Howard Liljestrand** at the South Shore Hospital, Aiea.

Licenses to practice medicine in the Territory of Hawaii were issued in May to **Dr. Raid B. Chappell** and **Dr. James R. Bobbitt.**

**Dr. Jerome Livingston Rosengard** has been appointed Chief of the Bureau of Venereal Diseases and Cancer Control. Dr. Rosengard is a graduate of the University of Illinois School of Medicine, class of 1926. He interned at Mount Sinai Hospital, Chicago. He was formerly on the faculties of Harvard University and Stritch School of Medicine of Loyola University, in the department of internal medicine. During the war Dr. Rosengard served in the Army and retired with the rank of Lt. Colonel.

The Medical Group announces the opening of its Kailua office at 539 Kailua Road. **Dr. John R. Sedgwick, Jr.** will be in charge. Specialists from Honolulu will be available on regular schedule.

**Dr. James T. Higa,** formerly of Honolulu, died in Chicago during the latter part of April. Dr. Higa was a graduate of the College of Medical Evangelists at Loma Linda. He had been practicing in Chicago for the past seven years.

**Dr. Robert H. Marks,** Chief of the Bureau of Tuberculosis of the Territorial Department of Health, left in May to attend the Pan-Pacific Tuberculosis Conference in Manila.

**Dr. Laurence Thouin** left for Chicago and other mainland cities in May to visit the obstetric and gynecologic departments of various hospitals and clinics.

**Dr. Frank Spencer,** Honolulu obstetrician and gynecologist, will see patients in consultation by appointment only in Kailua at 507 Uluhau Street.

**Dr. Gilbert Halpern** has been cited as the photographer's photographer in a recent feature article in the Honolulu press. Dr. Halpern has made significant contributions to medical photography in the Territory. His exacting photographic technique with resultant clear, life-like pictures is familiar to many local surgeons whose operations he has filmed.

**Dr. R. O. Brown** recently left for the mainland to attend the meeting of the American Urologic Association in St. Louis. Also off to the mainland were **Drs. Charlotte Florine** and **Teru Togasaki** to attend the meetings of the American Medical Association in New York.

**Dr. Vernon Boido** is taking **Dr. Thomas Mar's** place at Hana, Maui, for a period of ten weeks beginning May 25, 1953.

**Dr. and Mrs. K. S. Tom** attended the meeting of the American Gynecology Society held at Lake Placid from June 14 to 17.

**Dr. W. H. Civin** spoke before the Sisterhood of the Honolulu Jewish Community. The title of his address was "From Bread Mold to Atom Bombs."

**Dr. Bessie T. Strongman** of Honolulu joined the staff of Kalaupapa Settlement in May.

Saint Francis Hospital announces that the Director of Pathology, **Dr. Raid Chappell,** has been elected to membership in the American College of Pathologists.

**Dr. Harold M. Johnson** presented a paper at the recent meeting of the American Dermatological Association in Lake Placid, New York. Dr. and Mrs. Johnson and their son Larry spent a month on the mainland.

**Dr. and Mrs. Thomas H. Richert** and sons are touring the mainland by station wagon.

**Dr. John J. Lowrey** of the Straub Clinic was married on July 10 to Catherine Wishard Bingham.

**Drs. Fred I. Gilbert, Jr., George Ewing** and **George Garis** were elected to partnership in the Straub Clinic in June.

**Captain Casimir A. Domzalski, Jr.** was called to active service in the Army May 26. **First Lieutenant Stanley S. K. Wong** was called up on April 16. **First Lieutenant Frank Joseph Sykes,** formerly of Yap, received his call for June 22.

We are happy to welcome back from two years of Army service **Dr. Yasuyuki Fukushima** and **Dr. Kwai Sung Chang.** Dr. Fukushima returns to the practice of general surgery in the Medical Arts Building and Dr. Chang to the City and County Emergency Hospital.

### Hawaii

Arrival of a baby girl to **Dr. and Mrs. Edwin Willett** of Laupahoehoe at the Laupahoehoe Hospital on April 14, 1953, weighing 7 lbs. 14 oz. This is the Willett's fourth child and second daughter.

A son weighing 6 lbs. 15¾ oz. to **Dr. and Mrs. John T. Jenkin** of Hilo at the Hilo Memorial Hospital on May 14, 1953. This is the Jenkins' third child.

A son, weighing 8 lbs. 8 oz., to **Dr. and Mrs. Robert J. Kaufmann** of Pahala at the Pahala Hospital on May 26, 1953. This is the Kaufmanns' fourth child and third son.

### Kauai

**Dr. Dorothy Kemp,** County Health Officer of Kauai, left for Honolulu on May 28, 1953 to assume a new position as Assistant Chief of the Bureau of Venereal Disease and Cancer Control of the Territorial Board of Health.

**Dr. Burt O. Wade** left for a trip to the mainland on May 28, 1953. He attended the American Medical Association Convention in New York City.

**Dr. Peter Kim,** Medical Director of Mahelona Hospital, attended the conference of the National Tuberculosis Association at Los Angeles. During his absence, **Dr. Frank Sykes** substituted.

## NEWS

### The American Congress of Physical Medicine and Rehabilitation

The 31st annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held on August 31, September 1, 2, 3 and 4, 1953 inclusive, at the Palmer House, Chicago, Ill.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

### Course in Postgraduate Gastroenterology

The National Gastroenterological Association announces that its Fifth Annual Course in Postgraduate Gastroenterology will be given at the Hotel Biltmore in Los Angeles, Calif., on 15, 16, 17 October 1953.

The Course will again be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Director of Medical Education, Cook County Hospital, Chicago, Ill., who will serve as medical co-ordinator.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 1819 Broadway, New York 23, N. Y.

# UMI MAKAHIKI I HALA*

#### Honolulu County Medical Society

New members voted into the society were:

**Wm. S. Ito**
**K. Takenaka**
**D. L. Burlingame,** transferred from Hawaii
**L. A. Honl,** transferred from Kauai.

#### Report of the Secretary (H. T. M. A.)

The total regular membership of the Association is 263, a decrease of 9 over the previous year.

#### Emergency Medical and Ambulance Service

This division of the Emergency Medical Service operates 21 Casualty Stations in strategic positions throughout the City and County of Honolulu. Each outside island has a similar arrangement though on a smaller scale. In Honolulu there are about 25 ambulances on hand at all times with a standby of 250 commercial vehicles converted to ambulances to augment the service.

#### Election of Officers (H. T. M. A.)

The Nominating Committee consisting of **Drs. Pinkerton, Strode** and **Withington** presented the following ballot:

President ..... **Dr. Douglas Bell**
Secretary ..... **Dr. A. V. Molyneux**
Treasurer ..... **Dr. Stewart Doolittle**
Maui Councillor ..... **Dr. R. J. McArthur**
(to replace **Dr. Gordon Lightner**)
Kauai Councillor ..... **Dr. S. R. Wallis**
(to succeed himself)

Action: The report of the Nominating Committee was accepted and the Secretary instructed to cast a unanimous ballot for the election of these officers.

#### Dengue Fever

Dengue fever, quiescent since 1912 in Hawaii, has suddenly made its appearance in Honolulu in the last few weeks.

* Ten years ago. From Volume 2, Number 6, July-August, 1943.

# Sixty-third Annual Meeting
## Hawaii Territorial Medical Association

**Wailuku, Maui, Hawaii**
**April 30 through May 3, 1953**

The Sixty-third annual meeting of the Hawaii Territorial Medical Association was held in Wailuku, Maui, Hawaii, with scientific meetings and exhibits being held in the Baldwin High School Auditorium. The following program was presented:

### SCIENTIFIC PROGRAM

*Excision of Bronchostenosis and Anastomosis,* by Paul W. Gebauer, M.D.

*Harada's Disease,* by H. E. Crawford, M.D. Thomas W. Cowan, M.D. (Discussant).

*The Effect of Kona Weather on the Asthma Incidence in Children,* by W. A. Myers, M.D. Saul Price, M.S. (Discussant).

*Primary Carcinoma of the Liver,* by J. G. Marnie, M.D. Gilbert C. Freeman, M.D. (Discussant).

*Hetrazan Therapy for Filariasis in Samoan Navy Dependents in Hawaii,* by C. M. McCandless, Jr., Cmdr., M.C., U.S.N.

*Education in Parenthood,* by Richard Y. Sakimoto, M.D., Mrs. Mabel Davis, R.N. and Mrs. Alice Kohler, R.N.

*This Era of Anxiety,* by R. J. McArthur, M.D.

*Clinical Application of Prophylactic Procedures against Cancer,* by Ian G. MacDonald, M.D., Associate Professor of Surgery, University of Southern California School of Medicine (by invitation).

*Endometrial Carcinoma,* by Frank C. Spencer, M.D. I. L. Tilden, M.D. (Discussant).

*Retroperitoneal Insufflation by the Presacral Route,* by Andrew L. Morgan, M.D. Herbert Chinn, M.D. (Discussant).

*Histoplasmin, Coccidioidin, Haplosporangin and Blastomycin Sensitivity in Hawaii,* by Harrison S. Paynter, M.D. Harry L. Arnold, Jr., M.D. (Discussant).

*Further Studies in Primiparous Labors at Kapiolani Hospital,* by H. E. Bowles, M.D.

*The Clinical Aspects of Liver Fluke Infestation,* by Grant N. Stemmermann, M.D.

### MEETINGS

*Advisory Committee to the Bureau of Crippled Children,* Thursday morning, Baldwin High School Auditorium.

*Advisory Committee to the Bureau of Maternal and Child Health,* Thursday afternoon, Baldwin High School Auditorium.

*Council,* Thursday evening, Wailuku Hotel.

*Territorial Association of Plantation Physicians,* Friday morning:

*The Future of Industrial Medicine,* by George Wilkins, M.D., President, Industrial Medical Association.

*Health Plans in Big Industry,* by Earl Lutz, M.D., Medical Director, General Motors.

*Woman's Auxiliary—Executive Board,* Friday morning, Maui Country Club—11:00 a.m.

*House of Delegates,* 11:30 Friday morning, Maui Country Club.

*Industrial Medicine and Medical Economics Panel Luncheon,* 11:30 Friday morning, El Amigo.

A brief presentation of various aspects of Medical Economics by local and mainland speakers followed by an open discussion of problems within the Territory in this field.

*Panel members:* W. H. Wilkinson, M.D., Moderator; Edward Holmblad, M.D.; Earl Lutz, M.D.; Leo Price, M.D.; Frank Hatlelid, M.D.; S. R. Wallis, M.D.; J. Alfred Burden, M.D.; F. J. Halford, M.D., and Joseph R. Veltmann.

*Cancer and Cardiovascular Surgery,* two breakfast panels, Saturday morning, Maui Grand Hotel.

*Cancer Panel:* A broad review of diagnostic, therapeutic and experimental aspects of the cancer problem. Laurence M. Wiig, M.D., Moderator; Ian G. MacDonald, M.D.; I. L. Tilden, M.D.; Satoru Nishijima, M.D.; P. S. Arthur, M.D.; Walter Quisenberry, M.D., and Thomas Fujiwara, M.D.

*Cardiovascular Surgery Panel:* Recent advances in clinical and x-ray diagnostic technics as well as surgical treatment of acquired and congenital cardiovascular disease in the Territory and elsewhere. Nils P. Larsen, M.D., Moderator; Albert H. Ishii, M.D.; C. M. Burgess, M.D.; Homer Izumi, M.D.; Herbert L. Abrams, M.D., and Francis K. Lum, M.D.

*House of Delegates,* Saturday morning, Baldwin High School Auditorium.

*Territorial Academy of General Practice,* 11:30 Saturday morning, Maui Grand Hotel.

### SOCIAL PROGRAM

*No Host Dinner* for doctors and wives, Thursday evening, Wailuku Hotel.

*Woman's Auxiliary Luncheon,* Friday afternoon, Maui Country Club.

*Ladies Golf Tournament, Bridge, etc.,* Friday afternoon, Maui Country Club.

*Cocktails and Dinner,* Friday evening, Maui Memorial Hospital.

*Sightseeing trips to Haleakala and Lahaina,* Saturday morning.

*Annual Banquet,* Saturday evening, Lani Wai.

*Golf Tournament,* Sunday morning, Harold S. Kushi, M.D., in charge.

*Picnic for doctors and wives* (Guests of Maui County Medical Society), Sunday afternoon, Maui Country Club.

### NOTES

Scientific papers presented have been submitted for publication in the HAWAII MEDICAL JOURNAL.

The Golf Tournament was won by Dr. Joseph Palma.

### PROCEEDINGS

The minutes of meetings and reports follow:

### MINUTES OF COUNCIL MEETING

**April 30, 1953 at 6:15 p.m.**
**Maui Grand Hotel, Wailuku, Maui**

*Present:* Dr. McArthur presiding; Drs. Richert, Ito, Chung-Hoon, Sanders (Maui), R. K. C. Lee, S. L. Yee, Orenstein (Hawaii), and Wallis (Kauai), who attended the meeting in the absence of Dr. Fujii.

*Minutes:* The minutes of the October 27, 1952 Council meeting were approved as circulated, on motion of Dr. Richert.

*Hawaii Medical Journal:* The following Journal editorial board was appointed for the year on motion of Dr. Ito:

Harry L. Arnold, Jr., Editor
Edith C. Bennett, Managing Editor
William John Holmes, News Editor
E. K. Chung-Hoon, Advisory Board
Hastings H. Walker, Advisory Board
Homer M. Izumi, Advisory Board
Nicholas Steuermann, Associate Editor, Hawaii
Richard M. Yamauchi, Associate Editor, Kauai
Harold S. Kushi, Associate Editor, Maui

*Editor's expenses:* As a token of appreciation for Dr. Harry Arnold, Jr.'s valuable services as editor of the Journal, the Council voted, on motion of Dr. Yee, to pay Dr. Arnold's registration fee, the charge for the tickets which he purchased for annual meeting lunches, breakfast and dinners, and his own plane and hotel bills during the meeting.

*AMA Expense:* The budget set forth in the Treasurer's report was presented by Dr. Richert. There was considerable discussion of the amount allowed for the delegate and alternate's expenses in attending the AMA conventions. In order to come as close as possible to balancing the budget, the Treasurer had recommended payment of "tourist" rather than "luxury" plane fares.

**ACTION: It was moved by Dr. Orenstein, seconded by Dr. Yee, and unanimously passed, that the Council go on record as recommending to the House of Delegates payment of full first class fares for the delegate and alternate in 1953, but in 1954 and thereafter, payment of full expense for the delegate and one half expense for the alternate.**

*Chronic Illness:* The annual report of the Chronic Illness Committee was read and discussed at length.

**ACTION: On motion of Dr. Orenstein, seconded by Dr. Ito, the Council agreed to advise the Delegates that we appreciate the work of the Chronic Illness Committee in the past, that we hope they will continue their work in the future, that we feel they should act only in a medical advisory capacity to other health agencies in the future, and that there are no funds available in the budget for this committee.**

*Annual Meeting:* Mrs. Bennett reported that Mr. Jackson, a teacher at Baldwin High School Auditorium, had been most helpful and resourceful in connection with setting up the annual meeting exhibits at the school. Dr. Burden had suggested asking the Council's advice about presenting him a check for $25.00.

**ACTION: On motion of Dr. Sanders, seconded by Dr. Richert, the Council agreed that a payment of $25.00 to Mr. Jackson should be charged to annual meeting expense.**

*Salaries:* The Council approved an increase of $10.00 a month in Miss Florence Isoda's salary beginning May 1, 1953 and a sum of $250.00 to be used for extra secretarial assistance during vacations, etc.

*Budget:* The Council agreed to add $565.00 to the AMA Convention allowance. With this one addition, the budget was approved unanimously, on motion of Dr. Yee, duly seconded.

*Hawaii Diet Manual:* The revised edition of the "Hawaii Diet Manual" was approved in principle, on motion of Dr. Richert, seconded by Dr. Sanders.

*Medical Fees:* Dr. McArthur pointed out that the Council makes all decisions in the field of ethics for the Territorial Association. He suggested encouraging all members to take out insurance to cover medical care and then charge each other for services rendered to physicians and their families. No specific action was taken.

*Adjournment:* Dr. Ito moved a rising vote of thanks be extended to Dr. McArthur for his services during the past year, after which the meeting adjourned at 9:45 p.m.

SAMUEL L. YEE, M.D.
*Secretary*

## BUDGET—1953-1954

| | |
|---|---|
| **INCOME** | |
| Dues | $ 9,500.00 |
| Journal Advertising | 9,800.00 |
| Journal Subscription | 2,250.00 |
| Annual Meeting | 1,100.00 |
| Interest | 47.00 |
| Miscellaneous | 150.00 |
| | $22,847.00 |
| **EXPENSES** | |
| Journal Costs | $10,100.00 |
| Audit | 85.00 |
| Postage | 225.00 |
| Rent | 1,080.00 |
| Salaries | 8,375.00 |
| Supplies | 250.00 |
| Taxes | 125.00 |
| Telephone and Telegraph | 250.00 |
| Travel | 100.00 |
| AMA Convention | 2,565.00 |
| Medical Library | 100.00 |
| Miscellaneous | 270.00 |
| | $23,525.00 |

## MINUTES OF MEETING HOUSE OF DELEGATES

**Baldwin High School Auditorium**
**Wailuku, Maui**

**Saturday, May 2, 1953 at 9:00 a.m.**

*Present:* Dr. R. J. McArthur (Maui) presiding; Drs. Chung-Hoon, Tompkins, S. L. Yee, Richert, Woo and Oto (Hawaii), Dodge, Felix, Freeman, Fujii, J. Lam, Vasconcellos, Bailey, Choy, Gebauer, Kometani, Marnie, Wiig, McCorriston, Wallis (Kauai), K. Izumi and Burden (Maui), Nelson, Quisenberry, Benson, Arnold, Jr. and other doctors and proxies to a total of 210 for consideration of amending the charter and by-laws.

The chairman called the meeting to order and called the roll.

*Minutes:* The minutes of the Delegates meeting of December 16 were approved as circulated.

*AMA Expense:* The Council minutes of April 30 were read. Dr. Richert, the treasurer, spoke of the necessity for trimming the budget to keep within our income and explained the action of the Council regarding the AMA delegate's and alternate's expenses.

**ACTION: On motion of Dr. Felix, duly seconded, the Delegates accepted the budget as approved by the Council, including the $2,565 for AMA convention.**

The Council's recommendation that in 1954 and thereafter the Medical Association should pay full expenses for the AMA delegate and half expenses for the alternate was discussed.

**ACTION: Dr. Vasconcellos moved that the action of the Council be accepted except that both the delegate and alternate be given full expenses first class in the future. The motion was seconded and carried.**

*1954 Annual Meeting:*

**ACTION: On motion of Dr. Marnie, duly seconded and passed, it was agreed that the next annual**

**meeting should be held in Honolulu May 13-16, 1954 with a registration fee of $10.**

*Charter and By-Laws:* Dr. Arnold, Jr. presented a general revision of the Charter and By-Laws of the Association, copies of which had been circulated on March 2, 1953 to all voting members, together with a notice that action would be taken on the amendments at this meeting.

Dr. Choy mentioned that he had brought his copy on which he had made numerous suggestions for corrections of errors in punctuation and grammar. It was agreed by those present that these minor corrections could be made in the final revision of the documents after the meeting. The revision was then considered page by page.

**ACTION: Dr. Richert moved approval of the charter and by-laws as amended at this meeting. The motion was seconded and passed unanimously. Also, on motion of Dr. Richert, a rising vote of thanks was extended to Dr. Arnold for his work on this committee.**

*Rehabilitation:* Dr. Dodge stated that Children's Hospital has offered to provide space and personnel and the National Foundation for Infantile Paralysis has offered funds for training personnel for rehabilitation.

**ACTION: On motion of Dr. McCorriston, duly seconded, this was approved.**

*Annual Reports:* For the first time the annual reports were submitted a month in advance of the meeting this year. They were mimeographed and circulated to the delegates for their consideration. This made it unnecessary to read all reports at the meeting; only those about which there was some question, were discussed. A few revisions were made in the reports at the request of the chairmen.

*Emergency Medical Service:*

**ACTION: A rising vote of confidence and appreciation was extended to the Emergency Medical Service Committee.**

*Advisory Committees:* The reports of the Advisory Committee to the Bureau of Crippled Children and the Advisory Committee to the Bureau of Maternal and Child Health were read. The Delegates felt they did not have sufficient information to act on the recommendations in each of these reports.

**ACTION: On motion of Dr. Arnold, Jr., the House of Delegates agreed to take no action on the reports of the Advisory Committees to the Bureau of Crippled Children and the Bureau of Maternal and Child Health, and referred these reports to the County Societies for their rejection or acceptance on behalf of the Territorial Association.**

**ACTION: Dr. Richert moved that these two committees have their reports in the hands of the executive secretary at least one month before annual meeting in the future. The motion was seconded and passed.**

*Health Education:* Dr. Nelson reported that the Health Education Committee had aired 43 "Your Friend, the Doctor" programs on the radio quite successfully. We lost our sponsor about 3 weeks ago, but have various possibilities for a new sponsor, including banks, trust companies, food products such as Heinz, canned milk, etc. KMVI is also interested in working out such a program to include Maui.

**ACTION: On motion of Dr. Felix, duly seconded, the secretary was requested to write a letter of thanks to the chairman of the Health Education Committee and the sponsor for the good work they have done during the past year. The motion also included a vote of confidence in the present committee and the authority for the committee to approve any sponsor whom they consider suitable.**

*Dr. Vasconcellos Report:* Dr. Vasconcellos reported on the special meeting of the AMA House of Delegates held in Washington, D.C. on March 14, at which he represented the Hawaii Medical Association. At that time the AMA delegates unanimously approved President Eisenhower's Reorganization Plan No. 1, which created a Department of Health, Education and Welfare, whereby Mrs. Oveta Culp Hobby as Chief of the Department became a Cabinet member. Dr. Vasconcellos also referred to a matter discussed at the Academy of General Practice meeting in St. Louis.

**ACTION: Dr. Vasconcellos moved that the County Societies be requested to consider the derogatory remarks recently made by Paul Hawley and Ewart Graham and make recommendations to the Hawaii Medical Association and the AMA regarding possible action. The motion was seconded and passed.**

*Chronic Illness:* It was reported that Dr. Gilbert wished to have certain changes made in the wording of this committee's report.

**ACTION: Dr. Felix moved that the Delegates accept the Council's action in regard to chronic illness. The motion was seconded and passed.**

*Reports Approved:*

**ACTION: On motion of Dr. Freeman, seconded by Dr. Choy, the delegates approved of the reports as amended.**

*Fee Schedules:* As pointed out by Dr. H. M. Patterson, chairman of the Fee Adjustment Committee of the Honolulu County Medical Society, in the past it was found better to have fee schedules compiled and revised by the Honolulu Society's committee. The question now arises in relation to the veterans' fee schedule. The possibility of the neighbor islands being represented on the committee had been suggested. The Honolulu committee is quite willing to carry on this responsibility, but felt the other islands should have a chance to express their opinion. Dr. McArthur stated that, hearing no objections from the neighbor islands, the present procedure was approved.

*Free Choice of Physician:* There was no discussion of HB 692 providing for free choice of physician by the employee in workmen's compensation cases. This bill had just passed the House in Honolulu.

*Election:* Dr. Robert Benson, chairman of the Nominating Committee, had presented the following slate of officers:

| | |
|---|---|
| President-Elect: | **Dr. Nils P. Larsen** |
| Councillors: | **Dr. Henry B. Yuen** |
| | **Dr. Homer R. Benson** |
| AMA Delegate: | **Dr. Homer Izumi** |
| Alternate Delegate: | **Dr. Richard S. Dodge** |

**ACTION: Dr. Arnold, Jr. moved that the nominations be closed and the secretary be instructed to cast a unanimous ballot. The motion was seconded and carried.**

It was generally agreed that advance presentation of the annual reports to the delegates and councillors was very helpful and that this procedure should be followed again in the future. The president expressed his appreciation to Mrs. Bennett and the meeting was adjourned.

SAMUEL L. YEE, M.D.
*Secretary*

## REPORT OF THE TREASURER

**T. H. Richert, M.D.**

The Medical Association's balance as of March 1, 1953, the beginning of our fiscal year, is $13,325.21, plus $1,431.24 in the Public Service Fund. During the past year we have been able to remain within our budget with the exception of one item—the Hawaii Medical Journal publication cost us more than expected. This was due to the increase in number of pages in the issues. Advertisements in the Journal, however, increased also and the income from these more than covered the rise in cost.

During the past year purchase of a metal filing cabinet and an adding machine was made. We made a change in our auditors. This has proven very helpful in many ways. There has been a general review of our financial structure and bookkeeping methods and the auditor has given our employees many helpful suggestions.

We were able to give an additional $400.00 to the Honolulu County Medical Library, which we had agreed to pay if funds were available. The fiscal year was ended with a surplus over the preceding year of $1,003.39. We appear to be on solid ground and solvent.

Attached herewith is the proposed budget for 1953-54. A financial statement submitted by our auditor is on file in the Medical Association office.

**HAWAII TERRITORIAL MEDICAL ASSOCIATION**

| INCOME | ACTUAL 1951-1952 | BUDGET 1952-1953 | ACTUAL 1952-1953 | BUDGET 1953-1954 |
|---|---|---|---|---|
| Dues | $ 9,487.50 | $ 9,600.00 | $ 9,600.00 | $ 9,500.00 |
| Journal Advertising | 8,047.84 | 8,575.00 | 9,611.21 | 9,800.00 |
| Journal Subscription | 2,424.47 | 2,425.00 | 2,187.30 | 2,250.00 |
| Annual Meeting | 2,281.52 | 2,000.00 | 2,110.04 | 1,100.00 |
| Interest | 30.90 | 31.00 | 46.88 | 47.00 |
| Miscellaneous | 168.41 | 175.00 | 148.87 | 150.00 |
| Medicine of the Year | ..... | ..... | 86.54 | ..... |
| | $22,440.64 | $22,806.00 | $23,790.84 | $22,847.00 |
| EXPENSES | | | | |
| Journal Costs | $ 8,968.89 | $ 9,875.00 | $ 9,939.49 | $10,100.00 |
| Audit | 75.00 | 85.00 | 85.00 | 85.00 |
| Postage | 222.05 | 275.00 | 188.24 | 225.00 |
| Rent | 900.00 | 900.00 | 930.00 | 1,080.00 |
| Salaries | 6,894.23 | 8,050.00 | 8,000.00 | 8,375.00 |
| Supplies | 120.43 | 175.00 | 194.86 | 250.00 |
| Taxes | 204.75 | 115.00 | 104.30 | 125.00 |
| Telephone, Telegraph | 203.02 | 250.00 | 217.67 | 250.00 |
| Travel | 100.00 | 175.00 | 61.05 | 100.00 |
| AMA Convention | 2,192.27 | 2,250.00 | 2,177.92 | 2,000.00 |
| Medical Library | 500.00 | 100.00 | 500.00 | 100.00 |
| Equipment | ..... | 150.00 | 137.63 | ..... |
| Council Expense | ..... | 135.00 | ..... | ..... |
| Miscellaneous | 252.36 | 270.00 | 251.29 | 270.00 |
| | $20,633.00 | $22,805.00 | $22,787.45 | $22,960.00 |

Although the 1953-54 budget is not quite a balanced one, it is necessary to bear in mind that every third year, such as this one when we have annual meeting on another island, the expenses are greater and the income is less. However, you will notice we had a net gain for the past two years.

The item budgeted for AMA Convention this year includes 2 round trips to New York (tourist fare) in June plus $400 for delegate's and alternate's expenses in June, and 1 round trip to St. Louis (tourist fare) plus $175 for expenses at the interim session, plus $25 which the AMA charges us for the Conference of Presidents and Secretaries. The saving in tourist fare compared to "luxury" fare amounts to $565.

The Salaries item includes an increase of $10 per month for Miss Florence Isoda beginning May 1, plus $250 for secretarial assistance during vacations, etc.

Although this past year's budget included a sum to cover the cost of Council dinners, no dinner meetings were held during the year. The Treasurer feels the state of the budget does not warrant paying for Council dinners except at annual meeting, when it is included as an annual meeting expense.

## REPORT OF THE SECRETARY

**Samuel L. Yee, M.D.**

The total membership of the Association in all classes is 521, of which 380 (4 less than last year) are paid regular members. By counties this membership is made up as follows:

| | REGULAR | ASSOCIATE | RETIRED | LIFE | MILITARY SERVICE | HONORARY | TOTAL, ALL CLASSES |
|---|---|---|---|---|---|---|---|
| Hawaii | 42* | .... | .... | .... | 2 | 1 | 45 |
| Honolulu | 300* | 94 | 4 | 10 | 12 | 11 | 431 |
| Kauai | 13 | .... | .... | .... | 1 | 2 | 16 |
| Maui | 27 | .... | .... | .... | .... | 2 | 29 |
| | 382 | 94 | 4 | 10 | 15 | 16 | 521 |

* One member exempt from dues.

The total number of physicians licensed to practice medicine in the Territory of Hawaii as of March 31, 1953, is 619. Of this number 461 are now residing in the Territory. Of these 430, or approximately 94 per cent, belong to the Hawaii Territorial Medical Association.

We have 390 active members of the American Medical Association and 94 associate members.

## SUMMARY OF ACTIVITIES OF THE HAWAII COUNTY MEDICAL SOCIETY

**Nicholas Steuermann, M.D., Secretary**

Twelve regular monthly meetings were held during the fiscal year. No special meeting was called.

April: Dr. Bosworth of Los Angeles spoke on the latest concept on the "Treatment of Tuberculosis."

Installation of new officers with Dr. Kasamoto presiding.

May: Dr. William Boyd of Toronto was the guest speaker of the month. His topic, "The Present Day Concept of Bronchogenic Carcinoma."

The report of the Territorial Medical Association meeting submitted by Dr. David Woo. Dr. Edwin Willett was accepted as a new member.

June: Mr. L. D. Rowlands of the Vocational Rehabilitation Service spoke on "The Rehabilitation of the Chronic Patients."

Hawaii County Medical Society endorsed participation in the Health Council. The uniform Industrial Accident Fee Schedule was introduced to the society.

July: Dr. Vasconcellos of Honolulu spoke on a brief history of medicine. He also spoke on the future plans of postgraduate education in Hawaii.

The Postgraduate Seminar Group was formed with Drs. Yuen, Orenstein, Matsumura and Oto. A semi-annual report was made by the treasurer.

August: Dr. L. G. Thouin of Honolulu spoke on "Principles of Treatment in Gynecological Endocrinology."

Dr. C. L. Phillips was retained on the active list and his county medical dues were waived.

September: Semi-annual dinner meeting held jointly by the Society and the Woman's Auxiliary to the Hawaii County Medical Society. Dr. M. L. Chang was selected to represent the Territorial Advisory Committee on Chronic Illness Disease. Dr. Archie Orenstein was selected to represent the Radium Advisory Board.

October: Dr. Morton Berk spoke on the "Fundamentals of the EKG."

The present health plan of the ILWU was discussed by the representative of the HMSA.

November: Movie entitled "Peptic Ulcer."

Dr. Robert Henderson was accepted as a new member of this society. Dr. Francis Wong was called to active duty by the U. S. Navy.

December: Movie entitled "Coarctation of the Aorta."

January: Dr. Samuel Allison spoke on the "Clinical Aspect of Skin Diseases."

Dr. James E. Mitchell of Kona was accepted as a new member. The surgical consultants to the Medical Indigent Program will be comprised of Drs. Mizuire, Kutsunai, Brown and James E. Mitchell. The Hawaii County Medical Society went on record approving the plans proposed by the stevedoring companies.

February: Dr. Edgar Mayer of New York City spoke on "Pulmonary Neoplasms."

Nominating committee was appointed. Dr. Henry Yuen was appointed to head the program.

March: The Annual Meeting was held at the Hilo Country Club. Election of officers for the fiscal year 1953-1954. Dr. McArthur, president of the Territorial Medical Association, visited the society.

## SUMMARY OF ACTIVITIES OF THE HONOLULU COUNTY MEDICAL SOCIETY

**William M. Walsh, M.D., President**

Following the Territorial meeting in the spring of 1952, a series of postgraduate lectures was given by Dr. William Boyd, noted pathologist. These lectures were outstanding both in context and in delivery. We feel indebted to the Hawaii Cancer Society for their financing of Dr. Boyd's lectures.

Two more outstanding lectures, by Dr. Selman Waksman, co-discoverer of streptomycin, whose trip was partially financed by the Oahu Tuberculosis Society, and by Dr. Howard Rusk, whose information on chronic illness and rehabilitation, stimulated much action. Dr. Rusk's trip was partially financed by the Oahu Health Council.

A special committee was appointed at the beginning of the past fiscal year to study malpractice—insurance and suits. This committee has come up with some interesting and excellent recommendations and it is hoped that the Society will adopt them in order to prevent needless out-of-court settlements.

At the present time 99.8% of the county society's membership are participating physicians in HMSA.

General membership meetings were dispensed with during July and August.

Special Board of Governors meetings during the year included: 1) a meeting to combat unfavorable newspaper publicity concerning the so-called polio epidemic, 2) a meeting to discuss labor management insurance plans, and 3) a special meeting called to discuss instructions for delegates to the Territorial Medical Association.

A special meeting of the membership was held to vote on the proposed ILWU medical plans. This meeting was attended by over 200 regular members and resulted in a unanimous stand by the society.

One regular membership meeting was held at the Oahu Country Club and it might be said that the movie shown at this meeting was one of the most outstanding ever made. We believe a special vote of thanks is due to Dr. Gebauer and Dr. Mitchell.

The Public Service Committee held an annual meeting with the Press and Radio which was an outstanding success. The Public Service Committee also has arranged the hiring of public relations counsel and has plans underway for the formation of the Credit and Collection Bureau.

The Legislative Committee has been very active and has reviewed all bills pertaining to health and expressed opinions concerning them.

Disciplinary action towards several members in the society has taken up a good deal of time of the Board of Governors during the year. Legal counsel has finally been obtained and activities in this line will be undertaken by the new Board.

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## SUMMARY OF ACTIVITIES OF THE KAUAI COUNTY MEDICAL SOCIETY

**Richard M. Yamauchi, M.D., Secretary**

The year 1952-1953 presented many challenging problems for the Kauai County Medical Society. It was a year in which many medical economic problems affecting the community were met and appropriate decisions made. Individually and collectively, the members were active in coping with these situations affecting the health and economy of the community.

One of the first things that the local members decided to do so that the meetings could be attended by more members was to amend the By-laws relating to the regular meeting date, substituting the word "Tuesday" for "Wednesday."

In the matter of the HMSA Fee Schedule, there was 100% participation by this Society. The members had also expressed a desire that the Veterans' Fee Schedule should conform to the HMSA Fee Schedule. It was the opinion of this Society that the HMSA was doing excellent work and deserved our whole-hearted support.

A Postgraduate Session was initiated during the past year, and the members have all expressed satisfaction with the speakers who have conducted these sessions.

The most important problem for the members to consider was the Medical Plan as recommended by Dr. Weinerman to the Labor group in the Territory. During the year the Stevedore Medical Plan, which was proposed by the Stevedoring Companies, was presented to the Society for their opinion. Since the benefits had been computed on an actuarial basis by the HMSA and the plan, in substance, had been approved by the HMSA, the Society also approved of the plan with the exception of the Maternity Benefit clause. The Society went on record as recommending that the maternity benefits be left on an indemnity basis similar to the current HMSA Fee Schedule offered to the general public.

The ILWU submitted to some individual members of this Society a Medical Plan for the union. At a special meeting the members were of the unanimous opinion that such a proposal from the ILWU should be rejected by the Society as a whole. To this effect, a letter was written to Mr. Jack Hall.

An important study and research was also initiated during the past year by the local Board of Health with the assistance and approval of this Society. This survey on the fetal death situation on Kauai should be valuable to the community as well as the Territory.

During the past year there were few changes in the personnel. Keith Kuhlmann left for military service and his place has been taken over by Richard Yamauchi. Dorothy Kemp, local Health Officer, returned after six months' study at the University of California with a degree of Master of Public Health. Our honorary member, Donald Chisholm, left for the mainland recently.

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## SUMMARY OF ACTIVITIES OF THE MAUI COUNTY MEDICAL SOCIETY

**Edmund Tompkins, M.D., Secretary-Treasurer**

There were twenty-seven active members in the Society during the year 1952-1953. One member has moved to the mainland but has not transferred membership. There are three physicians in the County who are not members yet, because of ineligibility. As soon as they obtain a Territorial license they have expressed a desire to join. In the meantime, these men have been welcomed to all meetings and have been attending.

During the year there were nine regular meetings held, two special meetings and two breakfast scientific sessions. At these breakfast meetings, held on Sunday mornings, we enjoyed symposiums conducted by visiting physicians from Honolulu, each session being limited to one field of medicine.

We were fortunate in obtaining speakers for several meetings, some from the mainland and others from Honolulu, to give scientific talks.

A great deal of time has been spent during the year at meetings in discussion of medical insurance plans. With growing interest in the community in some type of health insurance plan, we have tried to keep up with various developments. The HMSA representatives have visited at meetings often and the most recent development was the presentation of the Longshore Medical Plan.

With the completion of the Central Maui Memorial Hospital, arrangements were made so that all Medical Society meetings could be held there in the conference room. For the first time, the Society has a suitable and comfortable place to meet which is centrally located. We are indebted to the Central Maui Memorial Hospital Managing Committee for this privilege.

## REPORT OF THE CANCER COMMITTEE

**I. L. Tilden, M.D.**

Dr. R. J. McArthur, president of the Hawaii Territorial Medical Association, has asked me to render a report of the activities of the Cancer Committee for the past year.

First of all, I am sure we will all wish to pay tribute to the memory of the late Grover A. Batten, who was chairman of this committee for many years. I believe there is general agreement among physicians, as well as the lay public, that Dr. Batten made a tremendous contribution to the program of cancer control in Hawaii.

The cancer program in Hawaii depends on close cooperation among the following agencies: The Hawaii Territorial Medical Association and its county societies, the Hawaii Cancer Society and its various county chapters, the Territorial Department of Health, the nursing and dental professions, and hospitals throughout the Territory. I sincerely believe that Hawaii has attained a very high level of cooperation among these groups.

*Professional Education:* For the past several years, the Hawaii Cancer Society has brought to Hawaii an outstanding cancer authority to give the main address at the annual meeting of the Territorial Association and a series of lectures on Oahu and the other islands. Last year Dr. William Boyd, a noted pathologist, was our visitor, and this year Dr. Ian MacDonald, eminent surgeon and cancer authority, is to be our speaker. The postgraduate committee of the Territorial Association has cooperated very closely with the Hawaii Cancer Society in planning these lectures.

*Cytology:* A committee of five physicians with cytologic training have worked very closely with the Cancer Society in providing a cytologic service to physicians all over the Territory. This committee has supervised all technical aspects of this service and devoted a great deal of time to the examination of suspicious slides. During the year, the Maui chapter of the Hawaii Cancer Society trained a cytologic laboratory technician who will set up a laboratory on that island.

*Research:* The morbidity study financed by federal funds and supervised by the Hawaii Territorial Medical Association, the Territorial Department of Health, and the Hawaii Cancer Society has continued. A total of 3,765 cases have been included to date in this study. Significant variations in the incidence of certain types of cancer in our various ethnic groups have been noted. Dr. Raymond Kaiser, director of the Cancer Control Division of the National Cancer Institute, visited Hawaii during the summer of 1952 and made the following comment regarding this study: "Hawaii offers excellent possibilities for research in the varying incidence of cancer of certain sites in the different ethnic groups."

The Hawaii Cancer Society is in the process of making a study of mortality rates in certain racial groups, with particular emphasis on cancer of the stomach. A research committee composed of physicians was established by the cancer society, and is assisting in this study. There has been very close coordination between the mortality study conducted by the Hawaii Cancer Society and the morbidity study conducted under the auspices of the Territorial Medical Association and the Department of Health.

*Public Education:* Physicians on all islands have assisted in cancer education sponsored jointly by the Hawaii Cancer Society and the Territorial Department of Health. A group of Japanese-speaking physicians are assisting the program of education for the Japanese-speaking public, sponsored by the Hawaii Cancer Society.

*Tumor Clinics:* Tumor clinics have continued to function at Queen's, St. Francis, and Kuakini Hospitals in Honolulu. The Department of Health, the Honolulu County Medical Society, and the Oahu Chapter of the Hawaii Cancer Society cooperated with the hospitals in the management of these clinics.

## REPORT OF THE DIABETES DETECTION COMMITTEE

**Morton E. Berk, M.D., Chairman**

During the past year this committee has had one meeting. The decision to use a special type of testing material for the Diabetes Detection Drive was agreed upon. As chairman of the committee, it became my responsibility to obtain the Dreypak materials. Because of a shortage of one of the substances in the manufacturing process, the Dreypak did not become available until too late to be shipped out here for the November Drive. A Territorial-wide Detection Drive was, therefore, not done. It was carried out only on Oahu through the cooperation of the physicians.

At the meeting of the National Diabetes Detection Committee in May, I shall be able to get information and make arrangements for Dreypaks to be sent to us for the November Drive. I think this can be done without any cost to the Medical Association, and since our committee receives no allotment, we will have to depend on getting them without any cost, if we are to use them. We promise a better job for 1953-1954.

## REPORT OF EMERGENCY MEDICAL SERVICE COMMITTEE

**Robert B. Faus, M.D., Chairman**

This committee held only one meeting during the year, but the members have been consulted from time to time as to the availability of doctors or their essentiality for the maintenance of the national and local health, safety and interest. Recommendations have been requested and made by the various County committees and their suggestions have been carefully considered. Only one registrant has been deferred by reason of hardship.

We were fortunate in being able to hear Dr. Howard Rusk, chairman of the National Advisory Committee to Selective Service, during his visit here in Honolulu. It was notable that after his very clear, complete and concise presentation of the Doctors' Draft Bill and its pending revision by the Congress of the United States, no questions came from the floor, nor has the committee encountered any profound conscientious objections to military service on the part of any of our members.

During the past year the following officers have reported for active duty:

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|---|---|
| 1ST LT. NICHOLAS M. AZZATO | 1ST LT. EDMUND C. K. LUM |
| 1ST LT. EDWIN R. BALLARD | 1ST LT. NOBUYUKI NAKASONE |
| 1ST LT. GORDON Y. H. CHANG | 1ST LT. ROBERT A. MOOKINI, JR. |
| 1ST LT. RICHARD K. C. CHANG | 1ST LT. ROY R. OHTANI |
| 1ST LT. OLAF CHRISTOFFERSON | 1ST LT. KENNETH H. RUSCH |
| 1ST LT. SYDNEY T. FUJITA | CAPT. SHIGEO SHINKAWA |
| 1ST LT. ANDREW C. IVY | CAPT. H. JOSEPH SIMON |
| LT. (JG) ROBERT P. JAY | 1ST. LT. WALTER S. STRODE |
| 1ST LT. KEITH F. O. KUHLMAN | CAPT. TOKUSO TANIGUCHI |
| CAPT. KIKUO KURAMOTO | CAPT. I. SAM TASHIMA |
| CAPT. CYRUS W. LOO | 1ST LT. FRANCIS K. L. WON |
| 1ST LT. SAMUEL C. Y. LUI | LT. (JG) FRANCIS F. C. WONG |
| 1ST LT. CHEW MUNG LUM | 1ST LT. WARREN L. WONG |

To date Dr. Marion Hanlon is the only doctor who has returned to Hawaii after the completion of his military service.

It is expected that Hawaii will be required to furnish approximately two physicians per month for the re-

mainder of the year. We hope that doctors completing their two years of active duty, who are former island residents, will return to Hawaii and we would like your cooperation in helping them to reestablish their practice, keeping them informed of vacancies or locum tenens positions until they are again established in the practice of medicine. I wish to call your attention, again, to the fact that the committee is always willing to give consideration for initial deferment prior to entry into service. However, you must realize that more than two years have passed enabling you to get your affairs in order so that you may enter military service if and when called. Certain hardships are bound to result when anyone gives up his practice to enter the service. Yet we consider it an honor and a privilege to be able to serve in a medical department that offers so much in the way of training and experience for physicians.

I wish to thank the present County Advisory Committees for Emergency Medical Service for their advice and recommendations relative to physicians in their individual societies and for assisting in plans for civil defense activities in the event of disaster, natural or from war. You should be reminded that civil defense is a continuing necessity, war or no war. We have currently stock-piled in safe storage medical supplies amounting to approximately half a million dollars. Training supplies are arriving now that will enable you to organize units which will function in the event of disaster. This training program is a must for the coming year. It includes aid stations and professional hospital units, fixed and mobile.

It is recommended that you give serious consideration to the reappointment of those currently serving on the Medical Advisory Committee. If it becomes necessary to replace any individual member, careful consideration should be given to choosing a doctor who is competent to serve in such a capacity and has a thorough knowledge of the maintenance of civil defense and supplies.

## REPORT OF THE HEALTH EDUCATION COMMITTEE

**Tell Nelson, M.D., Chairman**

With the approval of the House of Delegates at last year's convention on the specific radio project as outlined by your committee at that time, active work was initiated. Due to the tremendous amount of detail work involved in developing broadcasts, the committee was increased so that first, the work load would not be too time consuming for any one member, and second, to bring in new ideas which would make for better patient-physician relations. Your committee members, Drs. S. D. Allison, William Ito, T. Allan Casey, Tommy Chang, Duke Cho Choy, Charlotte Florine, Tadao Hata, Albert Ishii and I. A. Kawasaki, have served most efficiently and with honor and have given many hours of their valuable time and efforts to the success of the project.

The entire year's work has developed around the Sunday afternoon radio program "YOUR FRIEND THE DOCTOR," sponsored and paid for by Dairymen's Association, Limited, and under the auspices of the Hawaii Territorial Medical Association. The weekly programs have continued from June 29, 1952 through April 12, 1953. The response from participating physicians has been most gratifying and the members of the Medical Association are to be highly congratulated on their interest and cooperation. In addition to our local physicians, we have been most fortunate in having several mainland visitors appear on the programs: Drs. Leon Unger of Chicago, Kenneth S. Landauer and Howard Rusk of New York. Several others in closely allied fields have also appeared: Mrs. Marjorie Abel, Mrs. Bessie Holzinger, Drs. Max Levine, Albert Lemes and Theodore Nishijima. Their appearance and information has added not only color but increased interest to the programs.

Spot announcements related to medical problems have been used on each broadcast. These announcements have included such organizations and groups as the Cancer Society, Mental Hygiene Group, Telephone Company, Physician's call service, HMSA, Polio Foundation, Heart Association, Diabetes week and several others of similar type. The announcements have been a great help in the integration of education of the public and of our programs.

The response from the public by questions, personal notes and letters has been most gratifying. Several of the visiting physicians from the mainland who have listened to the programs have inquired how they are set up and how to go about setting up similar programs for their county and state societies.

This year we again repeated our press-radio-medico dinner meeting, cosponsored by the Public Service and Health Education Committees of your Association and the Honolulu County Grievance Committee. This was our second meeting with the newscasters and proved to be highly interesting and informative to all present. Meetings of this type should be held once a year to clarify the atmosphere of public opinion and relations with press and radio and should be of great aid in establishing sound medical news releases for public consumption.

The following recommendations are offered as a basis for the continuation of work during the coming year:

1. Continue the radio program "YOUR FRIEND THE DOCTOR" weekly, if a suitable sponsor can be obtained and at *no* expense to the Association.
2. Investigate the possibility of foreign language programs over other stations. Several stations have expressed their desire to carry fifteen (15) minute programs as sustaining programs under the caption of "Public Service."
3. Investigate the possibility of using TV programs. These, it is felt, should not be employed more than once a month and not as a supplement to our regular programs, but rather as one of its regularly scheduled programs. They will require a suitable sponsor and at *no* cost to the Association.
4. Develop other fields and avenues of approach for propagating health education, through schools, and organizations of various types. Some of this work could be taken over by the Woman's Auxiliary working through women's clubs, social clubs, service clubs, school and PTA forums.
5. The Health Education Committee should be reorganized and enlarged: It should be set up into separate sections to better disseminate health educational material to the public. It is proposed that the committee be divided into the following groups:
   a. Radio and TV group: To develop activities and contacts with Radio and TV agencies and the Press.
   b. Research group: To develop other health educational approaches not now fully utilized.
   c. Auxiliary group: To work closely with the above groups in coordinating health information in schools, women's clubs, social clubs, PTA forums and other outlets, which will bring to the public reliable and sound knowledge of medicine.

Your committee wishes to express its thanks to Mrs. Edith Bennett and her staff for the many hours of work which they have given to the program during the past year. Without their help it is doubtful whether this project could have been successfully consummated.

To Larry Stevens of KGMB, moderator of the radio project, the Association owes a debt of gratitude. Without his untiring help and gracious manner of presenting

the subjects, the programs would not have met with the success with which they have been received by the public.

To our sponsors, Dairymen's Association, Limited, we wish to express our thanks and aloha for the support which they have given the physicians of the Territory in presenting reliable and informative materials on health and medicine to the many thousand listeners.

It is requested that the Secretary of the Association acknowledge our sincere gratitude for their cooperation.

## REPORT OF THE HAWAII MEDICAL JOURNAL

**Harry L. Arnold, Jr., M.D., Editor**

The 6 consecutive issues of the JOURNAL published through February 1953 have been a little larger than usual: 1 ran over 90 pages and 2 over 80, instead of the usual 72. However, the net ratio of advertising or revenue pages to letterpress or expense pages was slightly better than 1:1 for the year, with an excess of one advertising page, which is regarded as a little extravagant by the business manager and as a little penny-pinching by the editorial side of the staff—in other words, right on the *kinipopo*.

In the middle of this series of 6 issues Mr. D. M. Weller, formerly with the HSPA Experiment Station and now a free-lance advertising agent, was engaged on a commission basis to secure local advertising for us. Our gross income from this source for the 3 previous months had ranged from $332 to $376. In the last issue it was $691.50, and still going up.

For the fiscal year, the financial picture, in rounded figures is as follows:

| | |
|---|---|
| INCOME | |
| Gross Advertising Receipts | $11,300 |
| Subscriptions and Sales | 2,200 |
| Total | $13,500 |
| EXPENSES | |
| Commissions and Discounts | $ 1,700 |
| Printing and Postage | 10,000 |
| Total | $11,700 |
| NET PROFIT FOR YEAR | $ 1,800 |

If one-third—which seems about the right amount—of the Association's annual $8,000 salary outlay is charged against the JOURNAL, then it comes within less than $900 a year of being self-supporting. However, since we could hardly reduce our staff of 2 persons by one-third, let alone one-half it seems reasonable to claim the whole $1,800 as profit for the Association. This does not include, it should be noted, the paper "profit" represented by the value of exchange subscriptions to medical journals, and review copies of books, donated to the Medical Library. It is straight cash profit for the Association.

An instance of plagiarism by a contributor was called to our attention by the mainland dentist whose paper had been plagiarized, and we secured legal advice in order to protect the Association's interests. The matter was resolved amicably to everyone's satisfaction by Mrs. Bennett during my three months' absence, and was summarized by her in accordance with our legal advice in an editorial in the September-October issue. We do not expect to hear from it again.

The HMSA has continued to use the page allotted to it over a year ago, and Dr. Domzalski has continued to maintain his feature section, "This is What's New." The latter will not be continued any longer now that he has gone into the Army, however, unless a contributor can be found to maintain it.

It is a pleasure to be able to report to you that the HAWAII MEDICAL JOURNAL has become a distinct financial asset as well as a professional one, and to recommend its continued publication on the same basis as heretofore.

## REPORT OF THE INDUSTRIAL RELATIONS COMMITTEE

**Richard S. Dodge, M.D., Chairman**

The Territorial Industrial Relations Committee was organized in November 1952 at the request of the president of the Territorial Medical Association. Its primary objective was the accumulation of information relating to contractual medicine particularly as it pertains to the Territory of Hawaii. The committee was originated because of the conviction that "lay" organizations are becoming actively interested in the administration of medicine, and on occasions their concepts have not been readily available to the large majority of practicing physicians. If medical service is to be placed on the bargaining table by insurance carriers, industry, and labor, it seemed only reasonable that the individual physician should be aware of the transactions involving his services.

The committee has had numerous informal discussions with representatives of the following organizations: labor and management in the stevedore and pineapple industries, interested insurance carriers, Hawaii Medical Service Association, and the International Longshore Workers Union. The governing forces of the ILWU appeared dissatisfied with the system of medicine being administered to their employees, and were most desirous of obtaining complete medical coverage with no "out of pocket" expense to their individual employees. Various proposals were offered this organization, and finally the New York Life Insurance Medical Plan was accepted by the negotiating committees and has been in effect since March 1, 1953. Briefly, this plan consists of medical, hospital, and surgical benefits being provided to the stevedore employees and eligible dependents, the cost being distributed between the employer and the employee. The administration of this fund shall be performed by a Board of Trustees equally represented by both the management and labor organizations. Medical services are reimbursed to the physician on the basis of the New York Life Insurance Fee Schedule. It is well known that labor is most desirous of having this fee schedule accepted as complete payment for services rendered although no contracts regarding such an agreement are known to be in effect between physicians and the medical plan trustees. If this plan is successful, it may well act as a pattern for comparable medical coverage in other industries throughout the Territory.

Currently, the pineapple industry is in the process of negotiating somewhat similar coverage for their employees. The benefits they desire have been indicated, and various companies are presenting bids for the coverage. It seems doubtful if our HMSA could offer the medical benefits for the amount which large insurance companies have proposed. This is based in part on absence of detailed actuary experience in the Territory, the lack of reserve funds in the case of an emergency,

and definite reluctance on the part of many physicians to underwrite this organization at the present time. However, those physicians directly involved in medicine for the pineapple industry may desire to partially underwrite an HMSA plan as a trial venture on a limited time basis.

During its short span of existence this committee has concerned itself primarily with a more thorough understanding of the problems involved in management-labor medical relationships. On completion of the pineapple-medical negotiation, there may well be medical changes made within the sugar industry, and eventually possibly with the individual citizens in the population at large. On the basis of the committee's study, the following recommendations are presented to the members of the House of Delegates of the Territorial Medical Association.

1. That the physicians of the Territory protest the formation of a panel type of medical plan which in effect would tend to gradually eliminate the free choice of physician,
2. That action be taken to obtain preferably a physician majority, or at least a physician equality, in the number of members on the Board of Directors of the Hawaii Medical Service Association,
3. That in view of the recent advances made in insurance contract medicine within the Territory, consideration be given to the necessity or the advisability of a strictly "Doctors' Plan" which would allow the physicians of the Territory to directly control the commodity they are selling,
4. That all physicians be advised as to the necessity of unity in a common front in our organization particularly in view of the fact that contract medicine individually and by groups is becoming more widespread each year,
5. That this committee be retained in name, scope, and objectivity without formal member relationship with other committees or organizations, and be encouraged to continue this survey into the various problems of contractual medicine.

## REPORT OF THE POSTGRADUATE COMMITTEE

**John Bell, M.D., Chairman**

This is the third year that there has been a Postgraduate Committee for the Territorial Medical Association. This committee was instituted mainly because of the desires of the General Practitioners Society to satisfy the requirements of their national headquarters.

This year our work was largely exploratory. We held several committee meetings throughout the year. It was decided that we would attempt to provide speakers for the monthly outer island county meetings. The time and the subject matter were determined by the local societies.

Since we started late in the year, only two sessions were held on each of the islands. This may seem small, but it did involve a lot of spade and leg work.

We believe this work should be continued and expanded. Visiting teachers should be utilized when possible.

I wish to take this opportunity to thank the men who served as speakers. They all had a good time and were well received. I wish also to thank the secretaries of the local societies for their fine cooperation and interest.

## REPORT OF THE PUBLIC SERVICE COMMITTEE

**Samuel D. Allison, M.D., Chairman**
**May, 1952 - February, 1953**

This year's Public Service Committee was made up of seven medical members and one member representing the Auxiliary: Drs. R. C. Dusendschon, Sylvia Haven, Robert Katsuki, Fred Lam, Jr., John Lowrey, Toru Nishigaya, and Mrs. Peter Washko.

Throughout the year, the Committee met weekly or bi-weekly with most members participating in all of the meetings. The time spent in actual committee meetings represented approximately one month of physician effort. Many additional hours were spent by the members carrying out their particular phase of the committee work.

Two years ago, an emergency medical call system was conceived and put into operation. Last year this system was further developed, and this year the committee reviewed its progress, established it on a more satisfactory financial basis, and expanded the publicity concerning it. Dr. Toru Nishigaya was the committee member largely responsible for supervising this service. He was aided particularly by Dr. Sylvia Haven who arranged with the Telephone Company to provide space in the telephone directory for publicizing the service. In addition to the preferential treatment in the directory, an advertisement has been inserted in the classified section of the directory, descriptive cards sent out through the Welcome Wagons to new residents and distributed by the Board of Health to rooming houses and hotels, and publicity given on the Health Education Committee Program, "Your Friend, The Doctor."

Early in the year, it was suggested that medical public relations would be enhanced by good training of nurses and receptionists. Efforts were made to initiate a receptionist training program through the use of the Telephone Company facilities. The Woman's Auxiliary aided materially in arranging for this program, but unfortunately just at the time it was to be started the Telephone Company lost their training person so the course had to be delayed.

The Committee worked in cooperation with the Grievance Committee and the Health Education Committee toward the furtherance of public service. Programs were prepared for use on the radio series, "Your Friend, The Doctor," and individual questions were inserted into several programs dealing with public relations. The Grievance Committee was publicized through this medium. It is the belief of this Committee that the program, "Your Friend, The Doctor," has been of material value to the public relations of the medical profession, and that the Health Education Committee should be congratulated for doing an admirable job.

It was believed that new physicians in the community should be oriented with regard to the medical society and the physician's responsibilities to the community. This matter was discussed with the Board of Governors of the Honolulu County Medical Society, and arrangements were made through them to carry out this work.

Meetings were held with the Industrial Research Advisory Council of the Territory with regard to some of their programs. They were particularly interested in exploring mainland commercial outlets for poi.

The Consolidated chain of theaters presented the film, "Your Doctor." Our Committee aided in publicizing this film.

A public relations survey carried out two years ago was reviewed and studies were made of areas in which our public relations are at fault. Continuing studies of this problem should be carried out in an effort to solve them. The editor of the HAWAII MEDICAL JOURNAL has cooperated in providing space in the JOURNAL for the public relation fillers.

Arrangements were made with the American Medical Association to provide news releases to the Territorial papers by airmail in order that release dates here may coincide with those on the mainland.

Two years ago, press, radio, medical society dinners were suggested. Last year a dinner was held with the press. This year this very worthwhile effort was expanded to include the press, radio, and television people with the medical society represented by the Health Education, Grievance, and Public Service Committees.

It was the belief of the Honolulu County Medical Society that an expanded public program should be carried out. The Committee has met frequently with Public Relations experts in an effort to find suitable consultants for our program.

Recommendations:

1. Continue to develop the emergency-call system and the press-radio dinner and follow thorugh on the training of office personnel.
2. Re-evaluate the findings of the Clark survey and take effective steps toward correcting our deficiencies.
3. Expand the public relations program within the limits that it can be carried from year to year and develop a more active program designed to fight any in-roads on medicine that would alter the present doctor-patient relationship. This program should also endeavor to aid the physician in regaining the esteem formerly held by him in the community.

In order to carry on such a program and in order that physicians need not devote so many hours to work in which they are not fully qualified, consideration should be given to the employment of a secretary-manager for the Honolulu County Society who would be capable of carrying out certain public relations functions in addition to serving other useful purposes in the Society. There are a number of methods through which this service could be financed, some of which would entail little or no expenditures on the part of the physicians.

The chairman would like to express his appreciation to the individual members of the Committee for their aid and particularly to thank Mrs. Peter Washko, the representative of the Auxiliary, for working with us.

## REPORT OF THE PUBLIC SERVICE COMMITTEE

**T. Nishigaya, M.D., Chairman**
**February, 1953 - March, 1953**

Since Dr. Allison's report, the Committee has met with the representatives of the Mutual Telephone Company and the training courses for our office personnel will commence in April or May, 1953.

The Committee, cognizant of the vast changes in medical and socio-economic factors in the community, has had weekly meetings and other special meetings to interview individuals and PR councilors as well as PR and advertising firms to try to decide just how to initiate our medical PR program. The problems are many but we have gained much by those interviewed.

To date we have met with:

1. Mr. Dan Clark
2. Woodrum & Carney, Ltd. (Mr. Carney)
3. W. H. Male & Company (Mr. Male—Mr. Goris)
4. Vance Fawcett Associates (Mr. Vance Fawcett, Mr. Pete Radner)
5. Joyce Roberts, Mr. Nelson Prather, Mr. Stewart Fern
6. Mr. Henry F. Simms

The Committee has had serious discussions and feels that a long range PR program should be adopted by the Medical Society; that some method of raising funds for this program should be looked into. A medical credit and collection agency (as expounded several years ago by Dr. H. Izumi) might be feasible.

The Committee is unanimous in its opinion that an executive secretary's position be created within the society. With such an individual our public relations program as well as other projects might be more readily sustained.

## REPORT OF THE LEGISLATIVE COMMITTEE

**B. Allen Richardson, M.D., Chairman**

Your Legislative Committee consisting of Drs. Harry Arnold, Jr., John W. Devereux, Samuel L. Yee, H. Q. Pang, Richard K. C. Lee, Richard C. Durant, Richard T. Kainuma, Alvin V. Majoska; Frank St. Sure, Jr., of Maui; Archie Orenstein, of Hawaii; A. Webster Boyden, of Kauai, and I, met weekly during the 1953 Legislative session. The Legislative Committees of the Honolulu County Medical Society and the Territorial Medical Association met jointly.

We considered about 50 pieces of medical or related legislative bills. Each bill was brought up for discussion after which a decision to support, approve, refer or to take no action was made.

The Health Committee of the House of Representatives under the Chairmanship of Representative Dee DuPonte has been quite active. However, the Health Committee of the Senate under the Chairmanship of Senator Itagaki has had only two meetings. The first was entirely taken up on the subject of fluoridation of water.

The attendance at Health Committee meetings of the Legislature is a real problem. Usually, only one or two days' notice is given with the result that only a few members are able to attend these meetings. This is certainly a situation where a full time man such as a business manager could be of tremendous value to all of us.

I wish to thank those members of the Legislative Committee of the Territorial Medical Association who faithfully attended our committee meetings and for their time spent at the Health Committee hearings.

## REPORT OF THE WOMAN'S AUXILIARY TO THE TERRITORIAL MEDICAL ASSOCIATION

**Mrs. Katsuyuki Izumi, President**

The Territorial Medical Auxiliary has completed its fifth year with three organized counties and a paid membership of 227.

Two meetings of the Officers and the Executive Board were held this year.

Much correspondence took place between the National and the Territorial Auxiliaries. This year we had an active correspondence with the "Today's Health" Chairman. Magazines and posters were mailed to various island presidents. Many members are subscribing. "Today's Health" is an excellent magazine for reading in the doctor's office.

Mrs. Garton Wall, who attended the last year's National Medical Auxiliary Conference, will give her interesting report to the members at the Territorial Conference on Maui.

This year's National Auxiliary Conference will be held in New York City, Hotel Statler, from June 1st to 5th. Those who are interested in attending, please notify your president or Mrs. Bennett.

It has been a pleasure to serve as president of the Territorial Medical Auxiliary during the year 1952-1953. I deeply appreciate the splendid spirit of cooperation of the officers, the Executive Board members and each and every auxiliary member.

## REPORT OF THE BOARD OF MANAGEMENT MABEL L. SMYTH MEMORIAL BUILDING

**J. Warren White, M.D.**

Members on the Board of Management for 1952 were Dr. R. T. West, Chairman; Mrs. Ethel Brown, and Mrs. Lois Bell representing the Nurses' Association; Mr. A. L. Y. Ward representing the trustees of Queen's Hospital, and Dr. J. Warren White.

Six meetings were held during 1952. Besides the routine business, the following items will be of interest to the Medical Society:

Resignation of Miss Jessie Eyman and appointment of Mrs. Illa V. M. Storme as Manager of the Building, effective June 1, 1952.

Change in the proposed building plans:

The plan for enlarging the building to accommodate allied health agencies had to be discarded. New plans are being considered to enlarge the accommodations of the present occupants. Doctors and nurses will be solicited for contributions and other fund raising methods will be studied. A special building committee composed of the Board of Management with representatives from the Medical and Nurses' Associations and the Woman's Auxiliary will be formed.

Financial condition: The income to meet the budget fell woefully short of expectations and plans are being carefully studied to put the maintenance income on a firmer foundation. For this we will need the cooperation of every member. Any logical ideas you may have will be sincerely considered by the Board.

Replacements on the Board for 1953 are Mrs. Elaine Johnson replacing Mrs. Ethel Brown, Dr. Verne C. Waite replacing Dr. Rodney T. West.

## REPORT OF THE ADVISORY COMMITTEE ON CHRONIC ILLNESS

**Fred I. Gilbert, M.D., Secretary**

In June 1951 the Chronic Illness Committee was appointed by the president of the Territorial Medical Association following the recommendation of the Council that this be done. A summary of the progress made by this committee during the first year is to be found in the August-September, 1952, issue of the HAWAII MEDICAL JOURNAL.

After making as intensive a survey as was feasible, the committee made certain recommendations including one that a Governor's Commission on Chronic Illness be appointed. This recommendation was rejected by the House of Delegates in May 1952.

It was restudied by the committee and again presented to the House of Delegates in December 1952. At this time the recommendation was tabled. Subsequent meetings, including consultations with Dr. Leonard Mayo, Chairman of the National Commission on Chronic Illness, reaffirmed the conclusions and recommendations previously made. In essence these are as follows:

1. Chronic illness is a major problem to individuals and to this community.
2. Chronic illness is increasing and will continue to increase.
3. To intelligently attack the problem, close cooperation of the medical profession with other segments of the community concerned with chronic illness is necessary.

As an alternative to a Governor's Commission being appointed, the committee believes that personal interviews of representatives of other interested groups such as hospital associations, management and labor organizations, public welfare departments, etc., by the committee could be carried out.

This in effect would constitute a preliminary survey of the impact of chronic illness on the individual and community. At the conclusion of this, further recommendations could be made to the Territorial Medical Association for action.

At the last meeting of the committee on March 30, the following resolution was made and passed unanimously:

> Resolved that the Chronic Illness Committee of the Territorial Medical Association continue study of the problem of chronic illness in Hawaii. To accomplish this, a sum, not to exceed $500 or the equivalent in terms of secretarial help, shall be made available to this committee by the Territorial Medical Association. This fund shall be used to defray the cost of part time secretarial help and incidental expenses.

## REPORT OF THE ADVISORY COMMITTEE ON RADIUM

**Philip S. Arthur, M.D., Chairman**

The Radium Advisory Committee met on October 27, 1952 at the Mabel Smyth auditorium. The following members were present: Drs. Buzaid, Washko, Watanabe, Chang, McCorriston, Saunders, Orenstein, Wilbar, Moore and Arthur.

During the course of the meeting some recommendations were made. They were based partially on the contents of a letter to the Board of Health from Mr. F. A. Schramm dated October 21, 1952 and observations and opinions of various members of the committee. The recommendations are as follows:

1. A letter be sent to all the county societies recommending the use of multiple source applicators such as the Ernst and Campbell in the place of single high intensity tubes. The present supply contains a 50 mg. single tube and it was the concensus of the committee that this should be exchanged for other radium which was considered necessary to round out the present supply. The four 25 mg. tubes which the Board of Health now has should be satisfactory for any condition that calls for the use of the present 50 mg. tube.

These letters were sent and a reply was received from the Honolulu County Medical Society approving the recommendations of this committee as regards changing the single tubes for the multiple source applicators. A letter was also sent to the Board of Governors of the Honolulu County Medical Society.

2. The four radium "D" cells should be sold as they are not practical in the present program.

3. A letter be sent to the Hawaii Eye, Ear, Nose and Throat Society asking their opinion on the advisability of the purchase of an ophthalmic applicator. If one is desired the committee recommends the purchase of a radio-strontium applicator.

This letter was sent and a reply was received from the society stating that the members did not recommend the purchase of an ophthalmic applicator at this time.

4. The Obstetrical and Gynecological Society recommends the purchase of twelve 2 mg. needles of 2 cms. length and ten 5 mg. needles of 6 cms. length. With the return of the radium as noted in items 1 and 2, there should be sufficient funds available for the purchase of these new needles. This was unanimously approved by the committee.

5. Return the present Campbell applicator for one that will accommodate the present radium supply and the purchase of one more such applicator.

6. When radium is rented out by the Board of Health all the physical factors and the description of the radium in writing should accompany it.

7. When the Ernst and Campbell applicators are used, instructions for their care should also be issued in writing.

## REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF VENEREAL DISEASE

**H. M. Johnson, M.D., Chairman**

This committee was formed sometime last year to advise and give suggestions regarding therapy and diagnosis in venereal disease in Hawaii. This committee consisted of Dr. Walter Quisenberry, Dr. Harry Arnold, Jr., Dr. Sam Allison and myself.

We have not held a meeting or had reason to hold a meeting since the formation of this committee; therefore, there is nothing to report at this date.

## REPORT OF THE ADVISORY COMMITTEE TO THE PHYSICAL THERAPY ASSOCIATION

**Ivar P. Larsen, M.D., Chairman**

There were no meetings of this committee held during the past year and accordingly this committee has no recommendations to make at this time.

## REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF TUBERCULOSIS

**Stewart E. Doolittle, M.D., Chairman**

The Tuberculosis Advisory Committee met only once during the year, on November 18, 1952. The committee gave careful consideration to the advisability of extending the use of Lanakila Crafts Rehabilitation Center to patients who are handicapped by conditions other than tuberculosis. A question had been raised as to the safety of permitting cardiacs, arthritics and other types of rehabilitation patients to use the same facilities as the patients who have had tuberculosis.

Dr. Hastings Walker and Dr. Robert Perlstein of Leahi Hospital have stated that it could not be guaranteed that patients working at the Lanakila Center might not occasionally have a reactivation of their tuberculosis. Dr. Walker presented a record of 62 patients at Lanakila Crafts. Of these, 85 per cent were inactive and 15 per cent arrested cases. There were 13 readmissions of Lanakila patients to Leahi Hospital from July 1951 to November 1952. Of these 13 readmissions, 4 cases were found to be lightly positive just prior to their readmission to Leahi. Dr. Walker felt that the danger was therefore extremely slight.

Dr. Robert Marks of the Bureau of Tuberculosis stated that whereas there is some chance of patients' cases being reactivated, the danger is negligible because they are followed so closely.

The Advisory Committee agreed with these statements and felt that the danger of extending the use of the Lanakila Crafts facilities to other *adult* rehabilitation patients would be negligible. The committee believes the program should be expanded gradually and with discretion. Proper screening of patients for admission to the program and adequate medical supervision are essential. There should be a professional advisory committee including doctors in the various specialties involved.

If the program is properly organized and supervised, this committee feels it would be of great benefit to the community to make fuller use of the very fine facilities of Lanakila Crafts.

## REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF MATERNAL & CHILD HEALTH*

**Satoru Nishijima, Chairman**

Five meetings were held during the past year. Twelve maternal deaths were studied and they were as follows:

| | |
|---|---|
| Toxemia | 4 cases |
| Cardiac Failure | 3 cases |
| Hemorrhage | 2 cases |
| Nephritis | 1 case |
| Ruptured Uterus | 1 case |
| Criminal Abortion | 1 case |

* Not acted upon. Referred to County Societies.

One of the major problems confronting this committee was the very inadequate filling out of maternal mortality questionnaires resulting in a very incomplete reviewing of the mortality cases. At the same time, delay in sending in the answered questionnaires resulted in a slowing down of the committee's work.

Four infant deaths were reviewed and they were as follows:

| | |
|---|---|
| Hemorrhage from Cord | 1 case |
| Precipitate Delivery | 2 cases |
| Gastric Perforation with Peritonitis | 1 case |

Some of the other problems studied were as follows:

1—Fibrinogen study report about postpartum hemorrhage was made and the information circularized to all physicians.
2—Current data on immunization concerning dosages, contraindications and approved practices were reviewed and the information sent to all doctors.
3—The final recommendations on Rh testing and also on complete exchange transfusion were reviewed and the information circularized to all physicians.
4—The problem of the high premature death rate was reviewed and approval given to the Planning of the Premature Institute for April 1953.
5—The fetal waste study on Kauai was discussed and that program endorsed by the committee.
6—The problem of incomplete reporting of fetal deaths under 20 weeks gestation was discussed. No definite recommendations were made.

I recommended that the chairman of the Advisory Committee to the Bureau of Maternal and Child Health be appointed immediately after the annual meeting. In this way, he will be able to follow the progress of this committee throughout the whole year resulting in a more efficiently organized committee.

The recommendations of the committee are as follows:

1. That a letter be sent by the Advisory Committee urging the doctors of the Territory to completely fill in and return maternal and neo-natal mortality forms so that the committee can adequately evaluate the case.
2. Where the neo-natal and maternal mortality forms have been returned to the committee incomplete, funds are requested from the Bureau of Maternal and Child Health so that a committee physician appointed by the Chairman of the Advisory Committee may visit the doctor to complete the forms.
3. That the Maternal and Child Health Advisory Committee write a letter to all doctors urging that the delivery of an infant not be delayed either by force or by the use of anesthetics.
4. That any patient in labor or with a condition pertaining to labor should be admitted to the obstetrical floor; if not, the pregnant patient should be admitted to the indicated non-obstetrical ward and the pregnancy be considered incidental.
5. That suggested nursing guides for the maternity patient in premature labor and the emergency nursing guides for the care of premature infants be sent to all hospitals in the Territory, all nurses who attended the Honolulu Premature Institute, and all doctors in the Territory.

### Suggested Nursing Guides for the Maternity Patient in Premature Labor

1. Admission.—If labor is suspected in the patient past the 5th month gestation, admit to maternity section.
2. Notify nursery of patient's admission giving probable gestational age, religious preference, father's name, address, and phone number.
3. Absolute bed rest for patient.
4. Omit routine rectal examination and enema.
5. Pubic prep if in labor.
6. Nursing observation T.P.R.—B.P.—clean urinalysis to laboratory, check when last nourishment, supportive nursing supervision, reassurance, do not leave patient alone more than absolutely necessary.
7. Fetal heart tones. Determine average rate and check as indicated, at least every 30 minutes.
8. Fetal Distress. Report to physician at once and administer oxygen to patient (distress indicated by F.H.T. under 90 or over 160 or by irregularity, excessive activity, passage of meconium, or prolapse of cord).
9. Omit sedation unless specifically ordered for this individual case.
10. Prep of delivery room. Suitable suctioning equipment in working order, warm receiving blanket and crib, preferred stimulant, oxygen available.
11. In emergency delivery:
    a. Allow head to proceed gradually, never delay by pressure on head or holding legs together.
    b. No anesthetic to mother.
    c. Avoid clamping cord until all pulsation ceases.
    d. Receive baby in warm blanket and suction as indicated. Handle very gently.
    e. Transport infant to nursery in warm crib with oxygen.

### Emergency Nursing Guides for the Care of Premature Infants

(These are only suggestions for nurses to discuss with individual hospital medical staffs. The suggestions for the guides came out of the recent Premature Institute in Honolulu, and were reviewed by a committee of pediatricians.)

1. *Suction* P.R.N. by a soft rubber catheter or bulb very *gently*.
2. *Oxygen* and heat P.R.N. (That relatively high humidity is considered beneficial to premature infant.)
3. *Nothing by mouth* for 12 hours or until ordered by physician.
4. *Position.* Bassinet or incubator, flat, unless otherwise ordered. Turn on side but do not lower head for more than a few minutes unless written order.
5. *Medication.*
   a. Vitamin K 5 mgs. I.M. on admission to nursery.
   b. Suggested drugs for stimulants (to be given by doctor's orders)
      (1) Caffeine with sodium benzoate .1 to .3 cc by hypo of 0.5 gram—2 cc ampule. Repeat every 2 hours P.R.N.
      (2) Adrenalin (1 to 1000 solution) 0.1 cc (1/10 cc) by hypo.
      (3) Coramine .1 to .3 cc by hypo.
6. *Formulae.* Give feedings of water or glucose until they have been tolerated well. Omit all feeding until further orders if baby is in distress.
7. *Weight.* Every other day.
8. *Temperature.* Every three hours until stabilized, initially by rectum; then axillary if desired. (Gradual stabilization of body temperature towards normal with narrow fluctuations is preferable to a sudden return to normal with sharp fluctuations.)
9. *Skin.* Allow the vernix to absorb. Soiled areas may be cleansed with water.
10. *Visitors* in nursery. All persons not permanently assigned to newborn care should thoroughly wash hands and put on gown, cap, and mask.

## ADVISORY COMMITTEE TO THE BUREAU OF CRIPPLED CHILDREN*

The 1953 meeting was held in the library of Baldwin High School, Wailuku, Maui.

The following attended:

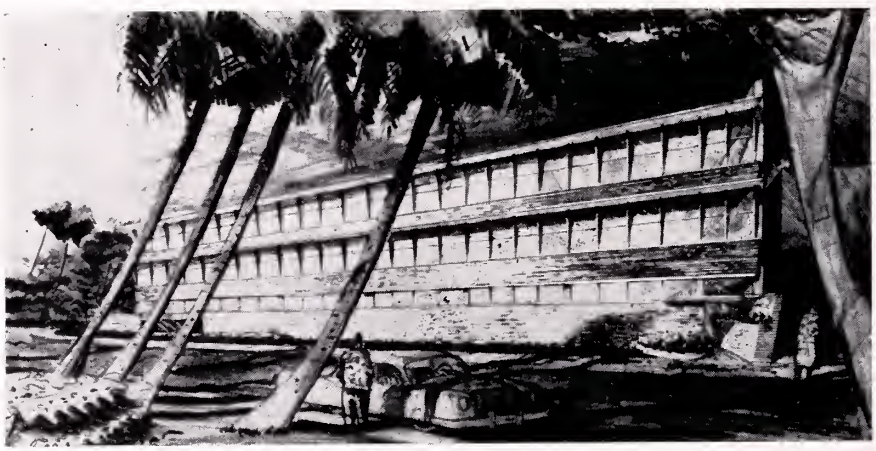
| | |
|---|---|
| Dr. J. W. White, *Chairman* | Dr. E. A. Tompkins |
| Dr. J. P. Fraser | Dr. Samuel Wallis |
| Dr. Wayne Wong | Dr. S. K. Wong |
| Dr. Ivar Larsen | Dr. W. Quisenberry |
| Dr. John Holmes | Dr. Dorothy Kemp |
| Dr. G. A. Dinwiddie (Dentist) | Dr. Angie Connor |
| Dr. H. E. Crawford | Dr. Katherine Edgar |

The recommendations of the committee are as follows:

1. That blind children not be registered with the Bureau of Crippled Children of the Department of Health, but that this function remain in the Bureau of Sight Conservation.
2. That a committee of three be appointed, one each by: (1) Pediatric Society; (2) Surgical Society; (3) Cardiac Advisory Committee of the Territorial Medical Society; to advise the Bureau of Crippled Children on each congenital cardiac case referred for surgery to the Bureau of Crippled Children, and plan disposition for the child. The referring physician should be invited to the meeting when his patient is being considered.
3. That medically indigent children on the Bureau of Crippled Children's program not be given financial assistance from the Bureau for care on an individual private case basis unless there are no institutional facilities available to give that care.

* Not acted upon. Referred to County Societies.

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**Note:**

Cobey,[3] reports not one person allergic to Melmac in applying 1000 casts.

*references:*


1. A. W. Spittler, Col., (M.C.), U.S.A., J. J. Brennan, Lt. Col., (M.C.), U.S.A., J. W. Payne, Capt., U.S.A.F. (M.C.), American Academy of Orthopedic Surgeons, Jan. 26-31, 1952, Chicago, Illinois.
2. M. C. Cobey, M.D., F.A.C.S., Professor of Orthopedic Surgery, Georgetown University and Senior Attending Orthopedic Surgeon, Children's Hospital, Washington, D.C., The American Surgeon, Vol. XVIII, No. 4, April, 1952, pp. 413, 415.
3. M. C. Cobey, M.D., F.A.C.S., Washington, D.C., private communication.





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# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAM, *Executive Secretary,* Honolulu

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## PRESIDENT'S MESSAGE

The annual meeting of the Territorial Nurses' Association will be held August 28, 29 and 30, on the island of Maui. The Maui District Nurses' Association has had an active planning committee working on this project since last October.

It promises to be a memorable event. The success of the venture will depend on the number of nurses attending. We hope to have the largest registration on record.

Won't you plan to come? The housing and transportation committees are making every effort to see that you will be comfortable. The program committee has professional and social functions planned which should be outstanding.

Save the date; plan to come; it will be worthwhile and very inexpensive!

ELIZABETH MCCALL, R.N.

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## THE STORY OF THE MABEL SMYTH BUILDING

(Continued)

### REPORT OF THE SITE COMMITTEE—SEPTEMBER 3, 1936:

The Site Committee of the Nurses' Association, City and County of Honolulu, met with the Site Committee, Nurses' Association, Territory of Hawaii, on Thursday afternoon, September 3, 1936, to discuss the Mabel Smyth Memorial Building. The territorial Site Committee stated that after conference with members of the Medical Society, Queen's Hospital Board of Trustees and Dr. MacEachern of the American Hospital Association in their opinion the site offered by Queen's Hospital was the most suitable one. The Committee feels that although their decision is that the Queen's Hospital grounds is the most logical site for the Mabel Smyth Building, the proposed terms of erection and the control of such a building should be presented to the members for their consideration, as well as the advantages and disadvantages which may accompany this location.

*Building terms:* Plans must be approved by the Queen's Hospital architect. The building must conform in style with that of the other buildings. The building would be the property of the Nurses' Association but the land would remain the property of Queen's Hospital.

*Control:* The control of the building would be by a committee of one physician or trustee of Queen's Hospital and three nurses. The balance of control would be in the hands of the nurses.

*Advantages of Building in Queen's Hospital:*

Tax free.

Free upkeep of the grounds.

Close contact with the physicians.

Convenience for the physicians because of the close proximity of the medical library and the auditorium for clinics.

The assurance of a good neighborhood.

Should the nurses not continue the upkeep of the building, Queen's Hospital would acquire it and it would still continue its purpose as a memorial to perpetuate the memory of Mabel Smyth.

*Disadvantages of Building at Queen's Hospital:*

Noise of gatherings in the auditorium may disturb the hospital patients. The land would not be the property of the Nurses' Association so the building would revert to Queen's Hospital should the Association cease to occupy it.

*From the minutes, Board of Governors, Honolulu County Medical Society, September 4, 1936:* Dr. Schattenburg made a short resume as to what has been done in the Mabel Smyth Memorial Building, referring to the amalgamation of doctors and nurses. The Physicians' Exchange will cost $5 per month for 24 hour telephone service. It was suggested that the Physicians' Exchange and the Nurses' Exchange be started on October 1 regardless of the progress of the new building.

*From the minutes, Board of Trustees, Nurses' Association, T. H., October 2, 1936:* Mrs. Akana reported a successful sale of tickets in Honolulu for the benefit movie "The White Angel." The amount of around $1500 was cleared, although no official report was given at this time. Plans are being made on Kauai to sell tickets at 75¢ and on Hawaii to sell tickets at $1. No information has been received from Maui as yet.

*From the minutes, Board of Trustees, Nurses' Association, T. H., November 26, 1936:* Letters were read from the Hawaii, Maui, and City and County of Honolulu Nursing Associations approving the Queen's Hospital as a site for the Mabel L. Smyth Memorial Building. These decisions make a unanimous vote for this site. The membership of the present site committee consisting of Albertine Sinclair, Dr. Bell and Stella Matthews was discussed with the view of adding more members. It was suggested that Alice Yates be requested to serve on this committee and that Dr. Withington's name be added; Mrs. Akana, president of the Nurses' Association and Dr. Schattenburg, president of the Medical Association, are asked to serve as ex-officio members. The motion was passed that the site committee be given power to act as it sees fit not only in the selection of the site but to transact any necessary business with Queen's Hospital in connection with this building.

A tentative proposal was submitted that we offer to pay part of the purchase price of the corner lot on Miller and Lusitana Streets with the view that that corner of Queen's Hospital property might be most desirable for this building. As soon as the site is decided upon, an official drive for funds will be launched. It is very desirable that this be done before the end of the year.

*From the minutes, Board of Governors, Honolulu County Medical Society, December 4, 1936:* Dr. Withington and Dr. Schattenburg were appointed to cooperate with the Nurses' Association in selecting a site for the Mabel Smyth Memorial Building.

*January 7, 1937:* Regarding the Mabel Smyth Memorial site, many conferences have been held. It was moved that a letter from the secretary should be directed to the nurses stating that the site should be further considered. The Board of Governors find the present agreed site unsatisfactory and reasons should be cited.

*From the minutes, Board of Trustees, Nurses' Association, T. H., January 28, 1937:* Miss Sinclair, chairman of the site committee, reported that the corner lot on Miller and Lusitana Streets had been selected by the committee. It was also stated that some of the doctors were not satisfied with this selection and wished the triangular lot immediately in front of the Emergency Hospital instead. Mr. Dickey, the architect, will be consulted as to the type of building which might be erected on this last mentioned site. It was agreed, however, that the approval of the Chamber of Commerce be obtained to launch the drive to start within the next two weeks, also that a statement be obtained from the Queen's Hospital to the effect that this building could be erected somewhere on Hospital grounds.

*From the minutes, Board of Governors, Honolulu County Medical Society, February 5, 1937:* There was further discussion regarding the site of the Mabel Smyth Memorial Building. Mr. Dickey, the architect, is drawing up tentative plans and is considering a site, style of architecture, etc. A very active campaign for funds is in the offing which, it is believed, will meet with generous response. The committee has asked for a medical group to represent the Society. The motion was passed that the president appoint a committee to represent the Medical Society. He appointed the following: Drs. Judd, Arnold, Hodgins, Withington, W. K. Chang and J. Kuninobu.

*March 5, 1937:* It was the consensus of opinion that only the doctors, nurses and Queen's Hospital should be represented in the governing committee of the Mabel Smyth Memorial. The site of the Memorial is still undecided and the field is being canvassed with recommendations expected shortly.

*From the minutes, Board of Trustees, Nurses' Association, T. H., March 24, 1937:* Mrs. Akana reported on the Mabel L. Smyth Memorial Funds stating that to date $21,000 had been received and that Mrs. Charles Adams had agreed to endow the medical library and pay for that portion of the building. It was moved by Mrs. Bohr and seconded by Mrs. Hickey that the reception room of the building be called the "Alice Yates Recep-

tion Room" in appreciation of the long and faithful services given by her to this Association. Motion carried.

*February 9, 1937:* Letter Chamber of Commerce to Nurses' Association giving approval to solicit funds to the amount of $100,000 for the Mabel Smyth Memorial building to be erected on the grounds of Queen's Hospital. Mrs. Akana announced that there was considerable clerical work attached to the project and that $25 had been allowed by the Nurses' Association and a like amount by the Medical Association to cover clerical expenses. The Bishop Trust Company requested authorization from the Board of Trustees to collect funds for the Mabel L. Smyth Memorial Fund and has recommended that this money be placed in a savings account. The secretary was instructed to write the Bishop Trust Company that this motion was carried. It was further announced that Dr. Braly, Director of the Gleemen's Association was offering a benefit concert by that organization, the proceeds to be used for the Mabel Smyth Memorial.

*Minutes, House of Delegates, Nurses' Association, T. H., in convention April 27, 1937:* Mabel Smyth Memorial—plans approved with the addition of a nurses' library separate from the reception room later to include a lending library to the outside islands.

*Minutes of the Council, Hawaii Territorial Medical Association, May 1, 1937:* Dr. Phillips announced that a $20,000 donation had been received from Mrs. Charles Adams and the Dillingham families for a physicians' library which is to be a part of the proposed Mabel L. Smyth Memorial building.

*Minutes of the Board of Trustees, Nurses' Association, T. H., June 16, 1937:* Mrs. Akana reported that approximately $43,000 donated in cash has been received for the Mabel L. Smyth Memorial with a promise of $20,000 additional for endowing a library. A check of $50 from the Kauai Nurses' Association has been received and turned over to the Fund Committee. It was stated that the site for the building has been promised on Queen's Hospital grounds. A committee composed of Stella Matthews, Albertine Sinclair and Elsa Chillingworth are empowered to act for the Association when this matter comes up.

*July 14, 1937:* The president presented a tentative plan outlining the purposes of the Mabel L. Smyth Memorial building drawn up by Dr. Arnold. Enough copies are to be made of this to send to each of the trustees for their consideration for the next meeting. A special committee, the Mabel Smyth Memorial Finance Committee, was appointed. Membership: Mrs. Thelma Akana, Laura Hooker, Elsa K. Chillingworth, Bess Young, Mabel Wilcox for Kauai, Marion MacMillan for Maui, Gwendolyn Shaw for Molokai, and Jean Fraser for Lanai.

*Minutes, Committee for the Mabel L. Smyth Memorial Fund, July 15, 1937:* Present: Mrs. Akana, Miss Matthews, Miss Sinclair, Drs. Judd, Withington, Chang, Arnold and Hodgins. A discussion was held regarding the use and the management of the building. A plan was submitted by Dr. Arnold and it was accepted by the members present. It was decided to ask the advice of a lawyer regarding incorporating or any further advice. Mrs. Akana will engage Mr. Kai for this purpose.

*Minutes, Board of Trustees, Nurses' Association, T. H., December 20, 1937:* Three new committees will be appointed by Miss Sinclair and Mrs. Akana to work out plans for the building, administration of the building, and activities for the building.

*February 21, 1938:* The committee recommended that the building not be started until after March as building costs are expected to come down.

*Annual Meeting, Nurses' Association, T. H., March 1, 1938:* Discussion of the proposal to make the basement portion of the Mabel Smyth Memorial originally intended for a social hall temporarily into locker and dressing rooms for the use of private duty nurses, thereby fulfilling a serious need for Queen's Hospital. The Queen's Hospital proposes to make financial or other agreeable arrangement by either furnishing the locker and dressing rooms or paying rental for their use. General agreement was expressed that Queen's Hospital should be allowed the use of this space.

*Minutes of the committee, Mabel Smyth Memorial Fund, May 12, 1938:* The starting of the Mabel Smyth Memorial Building was discussed. It was agreed that the cost of building has decreased and now is the time to start the building. Miss Sinclair will contact Mr. Dickey and discuss the building and report back to the committee.

*Minutes, Board of Trustees, Nurses' Association, T. H., May 13, 1938:* The president reported that there is a total of $89,474 in the fund. Additional members appointed to the Mabel Smyth Memorial Committee are Elizabeth McKay, Jessie Eyman and Isabel Winter.

*Minutes of the meeting of the Board of Directors, Queen's Hospital and the Mabel Smyth Memorial Building Committee, June 28, 1938:* Present for Queen's Hospital: Mr. C. R. Hemenway, Mr. Bruce Cartwright, Mr. George I. Brown,

Mr. Carter Galt, Mr. A. R. Keller and Mr. W. H. McInerny. For Mabel Smyth Building Committee: Thelma Akana, Mildred Byers, Jessie Eyman, Stella Matthews, Margaret Rasmussen and Albertine Sinclair. Also present, Architect C. W. Dickey. Mr. Hemenway, vice president of the Queen's Hospital, presided. He stated that this meeting had been called primarily to talk over the new proposed plan for the Mabel Smyth Memorial Building which it is now suggested might include quarters for the graduate nurses engaged at the Queen's Hospital. One of the things which Queen's needs is additional room for the nursing staff, and the matter has been given very serious consideration by the Directors. The suggestion has been made that perhaps this building for nurses might well be combined with the memorial to Miss Smyth. Another matter comes into the picture, in that it is now proposed to erect the building on Beretania Street frontage. This property is held under a lease from the Bishop Museum and under the terms of the lease can only be used for hospital purposes. The Mabel Smyth Memorial building as originally planned could not be considered as a hospital building, but if quarters for nurses should be included, the building could probably be erected on the land under lease from the Bishop Museum. Mrs. Akana submitted the following brief financial statement of the Mabel Smyth Memorial Committee:

| | |
|---|---|
| In savings account at Bishop bank | $52,853.35 |
| Pledge from Mrs. Adams and Mrs. Dillingham | 25,000.00 |
| Pledges from various firms | 2,450.00 |
| Miscellaneous | 587.00 |
| | $80,890.35 |

In addition there are two rather large pledges which will bring the total to about $90,000. Architect Dickey submitted tentative plans for the building which would combine those features originally planned for the Memorial building and the nurses' quarters. There was a very full discussion of the matter and it was agreed that the Beretania Street site is the most desirable and that, provided suitable plans for the building can be worked out, it is satisfactory for the Queen's Hospital and the Mabel Smyth Memorial Building Committee to combine in one building the features of the building as originally planned and quarters for the graduate nurses employed at the hospital, the entire building to be known as the Mabel Smyth Memorial Building. It was felt necessary to consult with the trustees of the Bishop Museum to make certain that such a building will not be in violation of the terms of the lease under which the Beretania Street property is held by the Queen's Hospital, and Mr. Hemenway undertook to do so.

Architect Dickey was requested to present rough sketches of various plans suggested for the building, and it was decided to hold another joint meeting sometime next week to consider the plans.

Several months ago a form of agreement had been submitted to the Directors of Queen's Hospital from the Smyth Memorial Committee, outlining the plan for handling this building, but inasmuch as the plans for the building have now been changed, action on any such agreement is deferred until a definite decision is reached on the plans for the building.

*Minutes of the Board of Trustees, Nurses' Association, T. H., October 12, 1938:* Total cash and pledges reported amounting to $90,870.67. Voted to pay the architect's bill in the amount of $1989.72 for the plans of the building on the Lusitana St. site.

*December 31, 1938:* Letters to the members of the Nurses' Association, T. H., requesting approval of change of site from Miller and Lusitana to Beretania Street.

*Minutes of the meeting of the Mabel Smyth Building and the Finance Committee, February 23, 1939:* Present: Dr. Arnold presiding, Dean Keller, Mr. Dickey, Dr. Withington, Thelma Akana, Laura Hooker, Elizabeth McKay, Mildred Byers, Margaret Rasmussen, Jessie Eyman, Bess Young, Dr. Hodgins and G. W. Olson.

Mr. Dickey went over the plans. Contract price including air conditioning, floor covering, stacks and shelves in the library, and venetian blinds is estimated at $84,450.

Mrs. Akana presented the proposal of the Tuberculosis Association and the Hawaii Medical Service Association taking space in the building. To provide this space would involve an additional expenditure of $3,500 which these agencies would be willing to raise independently in addition to their regular contribution toward the maintenance of the building. It was voted that Miss Sinclair appoint a Specifications Committee and a Furnishings Committee, each with full authority to work with the architect, builders, and decorators. The names suggested for these committees were: Specifications Committee—Dean Keller, Mr. Olson, Mr. Wittam, one doctor and one nurse. Furnishings Committee—Mrs. Dillingham, Miss Castle, Mrs. McKay, Miss Eyman, Mrs. James Morgan and a doctor or doctors.

Dr. Arnold raised the question of who would be legally responsible for operations, and it was the understanding of those present that all dealings would be made through Queen's Hospital.

Dean Keller is to ask the Board of Trustees of the Hospital to prepare a plan by which the money would be turned over to the hospital for payments on the building. It was voted to authorize Mr. Dickey to go ahead with his plans, leaving two copies with the Specifications Committee.

A suggested plan of management was offered and discussed.

Dr. Withington suggested that the hospital be given a guarantee by the two incorporated associations, the Nurses' Association and the Medical Association, to provide as a first lien against earnings the necessary funds for maintenance of the building. A fair share of the maintenance was felt to be if the Nurses' Association and the Medical Association each carried one half. It was generally agreed to leave the matter of responsibility for the care and maintenance of the building to the Board of Management.

*Suggested Board of Management, Mabel Smyth Building:* The Board of Management shall consist of two (2) nurses, two (2) doctors and one (1) member of the Queen's Hospital Board of Trustees, not a doctor. The nurses and doctors shall be appointed for a term of two years, one to be appointed each year. Member of Queen's to be appointed as desired by the Board of Directors.

The Board shall meet monthly for the first year and thereafter at the call of the chairman.

Chairman to be elected by the Board.

Registrar of the Nursing Service Bureau to act as secretary of the Board, but shall not be a member of the Board.

Duties of the Board shall be:

1. To administer the maintenance fund.

2. To make annual reports to the medical society, the Nurses' Association and the Queen's Hospital Board.

3. To direct the registrar of the Nursing Service Bureau in her duties as superintendent of the building.

The care and maintenance of the building shall be the responsibility of the Board of Management. All expenses in connection with maintenance shall be approved by the Board.

The management of the Medical Library shall be under the direction of the Library Committee.

*Maintenance Fund:* The Medical Association and the Nurses' Association shall contribute to a fund for maintaining the building. A 50/50 share of maintenance expense was thought to be a fair arrangement between these two associations. These associations to guarantee to the Queen's Hospital the necessary funds for the maintenance of the building, such maintenance to be a first lien against the earnings of the associations.

A fee may be charged for the use of the auditorium by any agency other than the Medical Association or the Nurses' Association to help defray janitor service, electricity, and other expenses in connection with the auditorium. This fund shall be deposited with the treasurer of Queen's Hospital and administered by the Board of Management. Building expenses shall be considered as follows: water, light, janitor service, general repairs, cleaning material, air conditioning and upkeep. Each agency shall be responsible for the payment of its operating expenses. If other health agencies are given office space in the building they shall contribute to the maintenance fund of the Mabel Smyth building, the amount to be determined by the Board of Management.

(To be Continued)

## A.N.A. WORKSHOP

On May 13 and 14 a workshop for sections of state nurses' associations from three Western States, Alaska and Hawaii was held by the American Nurses' Association in San Francisco. Transportation was paid by the National organization, and fourteen nurses from Hawaii, elected by their sections, attended the meetings:

| | |
|---|---|
| Sister Mary Albert | Mrs. Gladys Leong |
| Miss Mary V. Cheek | Mrs. Marjorie Howe |
| Mrs. Rosie K. Chang | Mrs. Louisa Kimura |
| Miss Virginia A. Jones | Miss Millicent Larson |
| Mrs. Betty Rodrigues | Miss H. Eileen MacHenry |
| Mrs. Kiyoko Fujita | Miss Margaret Barnett |
| Miss Edith Bell | Mrs. Margaret Makekau |

The following are some reports received from the delegates.

### Institutional Nursing Service Administrators Section

Hawaii provided both atmosphere and leadership in the fifth regional workshop sponsored by the American Nurses' Association to give assistance to state nurses' associations with section reorganization problems and with the development of section programs. All six members of ANA headquarters staff present to help with the workshop were thrilled with the leis presented to them as were representatives from three states and the Territory of Alaska who received individual vanda orchids.

Hawaii accounted for 23% of the representatives to the workshop. Only the state of Washington and Hawaii had their full quota of representatives. Four representatives from Hawaii were either chairmen or recorders for the sessions of the seven occupational groups.

The first day was devoted to organizational problems involved in the new ANA; the second day, to methods of planning section programs so that nurses with the same functions would be able to work out their problems most effectively.

In the Institutional Nursing Service Administrators Section, the following points, of special interest to Hawaii, were highlighted:

1. Terms of office for section officers should be staggered. However, it seemed advisable that chairman and vice chairman be elected at the same

time. Terms of office should be for a period of two years.

2. Alternating meetings of sections and district nurses' association membership seemed preferable to having the section meetings precede that of the membership.

3. Head nurses should be invited to join the Institutional Nursing Service Administrators Section if they so desire.

4. Sections should set up realistic goals in terms of what they expect to accomplish in 1, 2, or 3 years. Priority should be given to the most pressing problems.

5. It is thought that the emphasis placed on *section* organization and functioning will do much to spread out participation in nursing association activities to all occupational groups.

6. This is a period of experimentation with our new ANA. There is no one answer to all problems. Perhaps some day it will be possible to have just one national nursing organization.

7. Chairmen of all sections should be members of the respective Board of Directors with vote. (This would need to be incorporated into NATH by-laws.)

8. In trying to increase our membership we should be practical as well as idealistic. Nonmembers should not receive the same benefits derived by members.

9. Administrative nurses sometimes have more difficulty in improving their economic security than other nurses because of their close relationship with hospital administration; contracts for nursing administrators may be one answer to this problem.

The two days of the workshop passed very quickly. The weather was ideal. California hospitality was indeed easy to take.

SISTER MARY ALBERT

The two days spent in San Francisco was a very busy and very worthwhile period. I spent my evenings with Esther Conroy, former Educational Director at Queen's, whom many Honolulu nurses will remember. She sends her aloha to all of her old acquaintances.

This conference was very stimulating and it was truly a workshop. It was interesting to see that all ANA sections are having many similar problems which can be solved only by our working them out together. The Institutional Nursing Service Administrators Section really has a job for itself. Our committees need to get busy, we need a dynamic program and our rules already need revising although they have so recently been adopted.

Emphasis seems to be shifting from simply obtaining new members to rendering additional services to the present members. Each section needs to ask itself frequently "Is this section doing its job?"

The time allotted for section activity at the Territorial Convention in August will be extremely valuable in getting our whole organization on a sound, stimulating operating foundation. All of us obtained many new ideas which should make membership in NATH something to be sought after, a privilege more than an obligation. I am deeply grateful for having had the opportunity to attend this two-day workshop.

MARY V. CHEEK

## Industrial Nurse Section

Apparently the weather even decided to be exceptional during the workshop. This was gleaned from the many remarks of the natives about the sun shining. Fortunately, I'm not allergic to strawberries or I would have arrived home a sorry sight from the quantities that I consumed. I had to hold myself in check in the department stores especially in the modern rattan furniture sections. The plays, "Gigi" and "The Top Banana" were also on my agenda plus seeing former island friends.

Getting down to serious things, I feel that one of the most important things clarified at the workshop was the definition of an industrial nurse. Nurses working in hospitals, employed by industry, may be members of the Industrial Nurse Sections. Meeting with representatives of Industrial Nurse Sections from Alaska, California, Washington and Oregon made me realize that we all had the same organizational problems such as clarification of the functions of the ANA, SNA, District, Sections and the NLN. This was again brought out at the general section and states meetings. We must not get frustrated with our "growing pains" associated with section organization!

H. EILEEN MACHENRY

Having been a participant at the ANA workshop held in San Francisco, May 13 and 14, I returned to Hawaii with a clearer understanding of the ANA section organization plan, also the work ahead to bring it into effect, and the need for cooperation in trying to solve the many problems.

The seven occupational groups met in small group sessions. Our industrial group consisted of seven representatives and we were fortunate in having Miss Agnes Anderson as our resource member. Topics discussed were the qualifications, functions and standards of nurses in the various occupational fields. Membership of a section, committees and purposes of sub-units, local units, and conferences were explained. Program planning and budgets for our section were also discussed. Some of the representatives brought up our own problems of economic security and professional liability insurance.

The workshop was interesting and stimulating and I hope there will be others held regularly so many more nurses will have the opportunity of attending them.

MILLICENT LARSON

## General Duty Section

First, I enjoyed the workshop tremendously and feel very proud that I was a part of it. The main object of the workshop was to discuss organization and reorganization of the sections on all levels. We discussed problems relating to this in particular. Of course we were also able to discuss problems in relation to our occupational specialty. It seemed we all worked very hard and also had similar problems. Two long days of thought and discussion resulted in inspiration in all of us to return to our respective "home lands" and really get to work.

If only all nurses could be so inspired to support their ANA and work toward common goals!

Our Territorial group has already formed a basis for putting to work the knowledge gained in San Francisco and we shall all be meeting again in the Territory very soon.

That I may contribute to our NATH in every way possible and help convey ideas and results of combined thoughts is now my desire.

BETTY RODRIGUES

## Private Duty Section

My trip to the workshop was both informative and interesting. I was especially impressed with Miss Collier who appeared to be serving as parliamentarian. She was well versed in parliamentary procedures, policies, and functions of the association.

The workshop opened with a general assembly whereby all state delegates were introduced. Hawaii as usual stole the scene and stood out with its hospitality. The presiding officers and registrars were presented with leis and vanda orchids were given to all the delegates. The vanda orchids were donated by Miss Aiko Yano.

After the general assembly, the sectional delegates from each state met in their respective groups as designated by the general chairman with the resource person. A chairman and a recorder were then chosen to head the group.

It was very interesting to note the progress made by the NATH Private Duty Section. We seemed to have gone along quite well with our organizational plans. Problems which had been bothering us for some time were clarified.

One of the recommendations made by the group to the general assembly was that we go on record as desiring a regional workshop every other year between biennial years. This was adopted by the group and will also be referred to the Executive Board.

The purpose of the workshop was to give assistance to the state or Territorial Nurses' Association with section reorganization problems and with the development of section programs. Its objective was to stimulate more effective planning among state, district and ANA sections; strengthening of relationships among these sections and the development of leadership within the sections.

The problems under discussion were:

1. Proportionate representation to house of delegates whereby the state association will select delegates from lists submitted by the district sections.
2. Number of nurses necessary to form a district section was then brought up. It was felt that the state association should determine the sufficient number of members necessary to form a district section.
3. Conference groups and subunits were defined and functions clarified. Subunits were deemed not applicable as private duty nurses are all on the same level and we do not have staff nurses, head nurses, supervisors, etc.
4. Necessity for section chairmen to be voting members of Boards of Directors. It is important that section chairmen be full voting members of Boards of Directors for interpretation of section activities since ANA membership is now through sections.
5. The importance of direct communications to each section member through state bulletins, section newsletters, etc., was stressed.
6. It was felt that in relation to program planning, the activities and program of a section should determine its budget.
7. In regard to registries, it was pointed out that registry policies per se are not the prerogative of the private duty nurse section to determine but that it was important to have private duty nurse representation on all registry committees. It was also recommended that the registrar be a registered nurse.
8. The subject of group nursing (more than two patients) was discussed. At this point, private duty group nursing was defined as caring for *two patients only* on an emergency basis. It ceases to be private duty group nursing but general duty nursing when more than two patients are involved.
9. The matter of the 40 hour week for private duty nurses was brought up. It was the consensus of the group that the 40 hour week was not feasible for private duty nurses to implement at this time. However, the group felt that a 40 hour week could be put into effect if and when there are nurses available at the time and if the private duty section nurses will be responsible for their own relief.
10. Standards of employment and standards of practice were differentiated.
11. The economic security program was discussed whereby the importance of carrying professional liability insurance was stressed.
12. The definition of a private duty nurse; functions, standards, and qualifications; personnel policies; overall ANA programs as part of section program planning, etc., were also discussed.

The group as a whole felt that we had gained a lot by discussing our problems, organizational plans, and exchanging ideas in a conference group. We left the workshop feeling it had served its purpose and the seeds had been planted and we know where to go from there instead of groping in the dark.

I went to the workshop with several questions unsolved and have felt that they have been answered or that I have received guidance as to how they can be solved.

GLADYS T. LEONG

## Educational Administrators, Consultants and Teachers Section

There were six of us leaving Honolulu for San Francisco on PAA Flight 842 Monday evening, May 11: Mary Cheek, Virginia Jones, Gladys Leong, Kiyoko Fujita, Louisa Kimura and I. We were the largest single group to be leaving on the same flight. Four representatives had left earlier in the week and four others were leaving the flight following ours. Anna Kahanamoku, PAA Representative; a PAA photographer; Miss Adam; our relatives and friends were at the airport to bid us Aloha and a successful workshop.

The trip, as usual, was most relaxing and comfortable. We had a delightful time chatting with friends and newly acquired acquaintances as well as sleeping. One of our first procedures on board the airliner was advancing our time three hours to be in line with the mainland time schedule and daylight saving time.

On arrival in San Francisco International Airport we were met by Mr. Brady, PAA San Francisco representative. He cordially welcomed us to the City of Hills and made himself available for any requests we might have.

Most of us stayed at the Bellevue Hotel, the site of the ANA Section Workshop. The hotel is on Geary at Taylor, in the heart of town—near the Clift Hotel and two blocks from St. Francis.

Since we arrived a full day ahead of our workshop, Gladys, Kay, Louisa and I spent the morning shopping. Edith Bell joined us later for lunch in Chinatown, three-hour sightseeing tour by bus, dinner at The Grotto, Fisherman's Wharf and seeing "Top Banana," a stage play, at the Curran Theatre.

The next morning we were ready, eager and most anxious to begin our sessions.

8:45 a.m.—Registration. Since we had ample leis and flowers, we presented the principal speakers and resource persons with our leis: Miss Wallen, Miss Whittaker, Miss Warnecke, Mrs. Hinkley, Miss Anderson, Miss Strubin and Miss Collier. Incidentally, Miss Collier is a most remarkable colored woman. She is one of the most alert and intelligent individuals I've met. She apparently knows ANA from A to Z. She seemed to be the resource person for the resource persons. Gladys brought enough loose vandas to distribute to the participants each morning. These were thoroughly enjoyed by all. Louisa's anthuriums were placed on the speaker's table.

9:00 a.m.—Roll call by states: Alaska, California, Hawaii, Oregon, and Washington. Miss Whittaker, who presided, gave a special warm welcome to us. Orientation to the two-day workshop occupied most of the morning for the 65 of us.

After the general session we met in small groups according to sections to discuss problems of organization or reorganization according to our needs and interest. There were nine of us including Virginia Jones and me in the Educational Administrators, Consultants, and Teachers Section. California: Mildred Brown and Agnes O'Leary; Alaska: S. Martin Burdick; Oregon: Olive Slocum and Lloydena Grimes; and Washington: Marie Nielson and Grace Cameron. Our resource person was Miss Judith Wallin. Our group got down to business immediately. Miss Brown and Virginia Jones were selected chairman and recorder respectively. The Educational Administrators, Consultants, and Teachers Sections in California and Alaska were not organized as yet. Many problems were brought forth and discussed. The general topic was on organization. Briefly the following ideas were expressed:

1. Attendance at district meetings decreases as interest in sections increases. Suggestions:
   a. Section meetings four times a year — district meeting monthly.
   b. Program of district meetings sponsored by different sections.
   c. Section meetings during hour preceding district meetings.
   d. Joint section planning for district meetings.
2. Clinical interest groups in education can meet through planned group sessions within the Educational Administrators, Consultants, and Teachers Section.
3. Problem of organizing sections when membership on district level is small. Committees representing occupational groups can be formed. If members are insufficient for state section, it was decided a conference group could be formed within special groups section.
4. Every effort should be made to encourage practical nurses to be organized on state level—then encourage practical nurses to ask for help through their organization.

Active participation prevailed. Each member had many problems to present and all contributed to the discussion. There was never a dull moment in our group and quite often more than one member wanted to enter the discussion at the same moment. Alaska had numerous problems of which many seemed peculiarly their own.

Again on the morning of the second day we met in our occupational groups. Stimulated by the discussion the day before, we began our meeting immediately. AGAIN Alaska monopolized the limited time with her individual problems. The group was most considerate and patient and advised Alaska the steps to take. Their annual convention was to be held the following week and they had many questions and problems to discuss. However, we were able to discuss the general topic of facilitating section programs and increasing membership. The problem under discussion was planning programs to stimulate membership.

Major ideas expressed were:

1. Increasing effectiveness of district meetings by increasing professional content of programs.
2. Increasing membership by:
   a. More effective programs.
   b. Committee participation, preparation and continuity:
      (1) Coordinator of committees
      (2) Committee manual
3. Responsibility of association for civil defense planning. Associations to fit into local defense plan.

After lunch we met with our state group. We were assigned to the Green Room. With Margaret Barnett and Margaret Makekau as chairman and recorder respectively, we set down the procedure to take when we returned. Later we met for a final general session where oral reports were given by the chairman or recorder of each section.

The workshop day was from nine to five. The sessions were stimulating. This workshop has certainly broadened my perspective not only in section organization but also in the ANA. I had so many problems that I needed help with. I found that other states had similar ones and more. We were ahead of many states. I feel that Alaska has profited most in this workshop. I feel that the haziness of organizing a new section is beginning to disappear. There is a bright future for the Educational Administrators, Consultants, and Teachers Section. Terms that were meaningless to me are now meaningful and important. A word like *subunits* was just another word to me but I found out how vital a part it played in section activity.

To me, the meetings, talking and being with leaders in ANA alone were worth a trip, for names and faces take on a new and interesting meaning now. Thus attending the regional conference in San Francisco was doubly gratifying.

ROSIE K. CHANG

This section, EACT, as we learned to call it at the workshop, had representation from hospital, collegiate and practical nursing schools. The group discussed many of the problems common to other sections such as increasing membership through effectiveness of meetings, how to meet the needs of special interest groups within the occupational section and special problems and needs of the practical nurse groups. The section found it had a special problem in differentiating its functions from

that of the NLN Division of Nursing Education. To help the section clarify its function, Miss Judith Wallin, who was our resource person from ANA, formulated a comparative statement of major activities of the ANA and NLN. Because I believe it will be helpful to all of us, I am including it here.

Major Activities

| *American Nurses' Association* | *National League for Nursing* |
|---|---|
| 1. Define functions and qualifications for nurse practice in the various occupational groups and for specialties within those groups. | 1. Work with allied professions and other interested groups to help communities meet their nursing needs. |
| 2. Recommend standards for nurse practice in such fields as public health, industry, nursing education, private practice, and nursing administration. | 2. Promote the organization and improvement of nursing services in communities, including defense areas where services are often inadequate. |
| 3. Promote legislation and speak for nurses on legislative action concerning general health and welfare programs. | 3. Study the kind of education nurses need to give good nursing service. |
| 4. Take periodic inventories of the Nation's nurse resources. | 4. Promote the improvement of educational programs in nursing and provide accreditation of such programs. |
| 5. Promote and protect the general welfare (economic, professional and social) of nurses. | 5. Give advisory service to community nursing agencies and counseling service to colleges, universities and communities regarding the establishment of educational programs in nursing. |
| 6. Provide professional counseling service regarding employment to individual nurses and to their employers. | 6. Interest young people in choosing nursing as a career; test and guide those who are interested so that the ones best suited are selected. |
| 7. Act as spokesman for nurses with the public and with official groups (professional, governmental) on a State, National or International basis. | |
| 8. Serve as official representative of American nurses in the International Council of Nurses. | |

VIRGINIA A. JONES

## Special Groups Section

*Office*

As the door closed on the Mirror Room thus ending the first Regional Workshop of the American Nurses Association, many new and different thoughts crowded my mind.

As your representative I hope to convey these thoughts so as to arouse inspiration in you as the workshop did in us.

The major change in my thinking was this: I had heretofore felt ideas for policy changes were directed from headquarters down. Now I find the reverse is true. Headquarters brought us together to find out our problems and let us air our views on what could be done about them.

We returned to Hawaii with concrete ideas of how we can better operate through our state, district and sectional groups. A firm determination to work harder than we've ever worked before trying to urge all graduates to become members of the association; because unless we have group action, we accomplish nothing.

Discussion:

| *Problems* | *Solutions* |
|---|---|
| 1. Membership | 1. Vigorous campaign at home. |
| 2. Wages | 2. Action through organized groups. |
| 3. Hours | 3. Adjusted according to community. |
| 4. Educational advancement | 4. Local legislation. |
| 5. Qualifications | 5. To be set and revised as we see fit. |
| 6. Functions | 6. To be determined by groups. |
| 7. Our poor public relations. | 7. A job for all. |

MARJORIE HOWE

## GENERAL DUTY SECTION

The Regional Workshop was very interesting and stimulating.

Although time was limited, we were able to discuss some of the important problems concerning the general duty nurses section.

I hope I will be able to put across to our nurses, who are non-members of our organization, why they should join the American Nurses' Association.

I personally have learned a lot from this workshop although I am new at this sort of thing.

I wish that all of the nurses could have an opportunity in the future to attend a workshop of this kind.

KIYOKO FUJITA

## REPORT OF PREMATURE INSTITUTES

Hawaii

The Premature Institute which was conducted on April 21 at Hilo Memorial Hospital proved to be very successful. This was largely due to the cooperation and interest displayed on the part of the 43 nurses who attended this day long session. The representation included nurses, both practical and graduate, from Hilo and the outlying districts such as Kohala, Laupahoehoe, Honokaa, Paauilo, and Pepeekeo; Hilo Sugar Company; and nurses with the Board of Health.

Miss Ethel Tschida, Consultant and Supervisor of Premature Nurseries and Instructor of Pediatrics at Cornell Medical Center, New York Hospital, conducted

the Institute with the able assistance of Mrs. Flora Ozaki, who is Maternal Health Consultant with the Bureau of Maternal and Child Health of the Territorial Department of Health.

A nurse well informed in all the problems of premature care, from predelivery right on through to the time the infant goes into the home, is a valuable asset to an obstetrical nursing staff, it was pointed out.

In spite of the short time taken to cover such a vast subject, much ground was well covered through the medium of lecture and demonstrations. Questions were answered freely, and this made everyone feel they were part of the discussions. Everyone who was fortunate enough to attend agreed that it was a very worthwhile Institute.

### Kauai

Kauai held two half-day sessions: one at Waimea Hospital and one at Wilcox Memorial. Forty-two nurses attended these sessions. Miss Tschida was accompanied by Miss Leona Rubbelke. The discussion was centered on the principle of nursing care of the premature infant. The public health nurses on Kauai held a two hour session with Miss Tschida on their part in the prevention and follow up.

### Maui

Maui held a one and one-half day session for professional and practical nurses. Dr. Katherine Edgar, Assistant Chief, Bureau of Maternal and Child Health, accompanied Miss Tschida. The public health nurses held a two hour session with Miss Tschida on the prevention and follow up aspects. Ten physicians met with Dr. Edgar and Miss Tschida following the Institute to discuss medical aspects.

## NURSES' ASSOCIATION, COUNTY OF MAUI

The Maui Nurses' Association bazaar, held in the latter part of April, was a huge success. Marjorie Okinaka was general chairman. The public health nurses, under the chairmanship of Hilda Yatsushiro, were responsible for the rummage sales. White elephants were the kuleana of the industrial nurses, led by Anne Gillin. Kula Sanatorium nurses, under the chairmanship of Elizabeth McCall, were in charge of plants. Concessions and contributions were handled by the Puunene Hospital nurses with Joyce Ishibashi and J. Watanabe as their leaders. The Pioneer Mill Hospital nurses, Central Memorial nurses and associate members, under the chairmanship of Mrs. Peg Weight, were responsible for the food sales.

* * *

Miss Wyoma Carey became Mrs. William Bradley in March. Loretta Woo, a recent transfer from Oahu Nurses' Association, and Doris Kagoshima have been transferred to Hana Hospital for three months. Miss Miriam Hamasaki has recently joined the Central Memorial Hospital staff as a physiotherapist. Mrs. Darrell S. Gwynn from California has recently joined the staff at Kula Sanatorium. Mrs. Phyllis Stubbs is replacing Natsuko Kubo while she is on a leave of absence from the Department of Health.

* * *

The Maui Nurses are in the midst of making plans so that your stay on Maui will be an enjoyable one during the annual convention in August.

## NEWS

Lucille Otto was the honor guest at the Kamehameha School PTA luau on May 19. She was presented with a beautiful orchid plant. Miss Otto is retiring after ten years as school nurse in the preparatory department of Kamehameha School. She has been active in nursing for forty years, thirty of which have been spent in Hawaii. She has been an active member of the Nurses' Association throughout her professional career, and has served as secretary and treasurer of the Nurses' Association District of Oahu, as well as on numerous committees of both NADO and NATH. Miss Otto served overseas in World War I as an American Red Cross Nurse, whose uniform she modeled in the fashion show at our last Convention. She plans to remain in Hawaii in her lovely home at 2036 Mauna Place in Honolulu.

* * *

Miss Gertrude Church, R.N., Regional Nursing Consultant of the Children's Bureau (San Francisco Office), has just completed a two weeks visit with the Department of Health. She was accompanied by Miss Virginia Insley, Medical Social Consultant.

The purpose of this first visit was to become acquainted with the programs of the Health Department and the community, and to learn the kind of health and nursing activities being carried out.

During a three day visit on Kauai, they visited orthopedic and pediatric clinics being held.

Because of their acquaintance with health programs in several western states and Alaska, they were able to make constructive suggestions regarding the work here.

Miss Church commented particularly on the fine working relationships between the public health nurses and the physicians.

## MARGARET JONES MEMORIAL FUND AVAILABLE FOR LOANS TO NURSES

The Margaret Jones Memorial Fund Committee is interested in making information regarding loans more generally known to Association members.

The income from this fund is available for loans to professional nurses who are members of the Association and have been members for at least two years. A new graduate who is a member of the Association for the current year is also eligible. These loans may be used for emergencies such as illnesses or emergency trips, for advanced nursing education or for other collateral purposes.

Direct gifts to nurses are sometimes made in cases of extreme need.

Loans are usually limited to $500.00, on which 2 per cent interest is charged.

Further information concerning loans may be obtained from Miss Leona Adam at the Mabel Smyth Building, or from Mrs. Marjorie Elliott—phone 52349.

MARJORIE ELLIOTT, *Chairman*
*Margaret Jones Memorial Fund Committee*

## ARE YOU INTERESTED IN A COMMUNITY CHEST SCHOLARSHIP?

This year only three nurses applied for the Community Chest scholarship! Nurses are missing a great opportunity for training in special fields.

The philosophy of the sub-committee which considers

all health scholarships is that a nurse should have had her advanced academic work at the University of Hawaii so that her scholarship request for mainland study will cover work in a special clinical field. This, of course, would considerably decrease the cost on the mainland. Matriculation may be in either the University of Hawaii or a mainland school.

Miss Virginia Jones, Director of the School of Nursing, University of Hawaii, will be happy to assist you in planning a program of study.

If you have not already started at the University of Hawaii, then enroll this fall and get some of the academic subjects behind you. You will find a satisfaction and stimulation in the work.

## JOB EXCHANGE

Miss Olga Larson, School Nurse at Farrington High School, will exchange positions with Miss Virginia Vogel from Fair Lawn High School in New Jersey. Miss Vogel is highly recommended as a school nurse and in addition is a concert pianist. She leaves San Francisco on the Lurline August 7 and will live at Fernhurst.

Miss Larson is looking forward to her year in New Jersey where she will be near her family.

## MISSING MAGAZINES

The Medical Library, Mabel Smyth Building, needs magazines to complete the files. If you have them to spare, we would greatly appreciate the following:

*Nursing World*
1952—May, July, October, November, December

*Nursing Research*
1952—June

Additional copies of *Public Health Nursing* would be very helpful.

## LEAGUE MEETING

Hawaii representatives to the first biennial meeting of the National League for Nursing, Inc. are: Miss Mary V. Cheek, Director of Nursing, Queen's Hospital; Sister Mary Albert, Director of Nursing, St. Francis Hospital; Miss Olga Larson, School Nurse, Farrington High School; and Miss Leona R. Adam, Executive Secretary, Board for the Licensing of Nurses and Nurses' Association, Territory of Hawaii, Inc.

## INTERNATIONAL COUNCIL OF NURSES

The International Council of Nurses will hold its tenth meeting at Rio de Janeiro on July 12-17. Mrs. Gloria Foster, Public Health Nurse, Maui, and Miss Mabel Gordon, Nurse Anesthetist, Queen's Hospital, are attending.

## ECONOMIC SECURITY*

How often have you heard this kind of remark—"I wonder what the new-fangled nurse is coming to, that she concerns herself with money problems!" I'm sure you've all heard people who say, "In *my* time we paid attention to the *patient's* welfare." By this they imply that concern for our own welfare means neglect of our patients.

Of course nurses are concerned about the welfare of their patients, but they are also—and rightfully—concerned about their own finances. There is no inherent incompatibility between a sound economic position and the fulfillment of the ideal of service. The problem is to fit the two together, to integrate them.

This is not a new problem. The ANA has always recognized that satisfactory working conditions are essential to the production of satisfactory nursing care; but the techniques used to obtain such conditions have in the past proved to be relatively ineffective. Long experience in other fields has shown that the impetus for improvement must come from the employees themselves; and so we nurses have finally recognized that leadership in improving our employment conditions is our own responsibility.

Realizing that this could be done effectively only by democratic group action, the ANA House of Delegates, at the 1946 Biennial Convention, took the action that started the Economic Security Program on its way. Its purpose is twofold—the same today as it was when it was conceived, namely:

> To secure for nurses, through their professional associations, protection and improvement of reasonable and satisfactory conditions of employment; and, through accomplishing this, to assure the public that professional nursing service of high quality and in sufficient quantity will be available for the sick of the country.

Remarkable improvements in working conditions have been made in the states that have full-fledged economic security programs. In addition, improved salaries and other benefits, established through the collective bargaining process in some areas, have set patterns which favorably affect the employment conditions of all other nurses in the country.

The long range results of the Economic Security Program will be to give the best and most service that the employer-nurse team is capable of. This does not exist when nurses are anxious about making ends meet, are ignored, or are not given the recognition they merit. Nor does it exist when the employer suffers from turnover or competition from areas outside the state. An economic security program results in stabilization of nursing service. A satisfied nurse stays put, and this benefits her, her employer, *and* her patients.

ADELE HERWITZ†

* From Massachusetts State Nurses' Association News Letter.

† Adele Herwitz is assistant executive secretary, ANA, in charge of the Economic Security Program.

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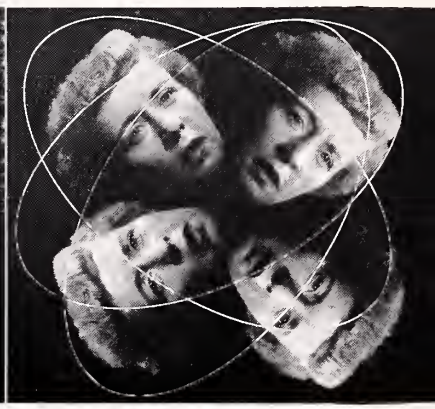
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1. *Dizziness . . . movement is within the head.*
2. *Objective vertigo . . . the environment is in motion.*
3. *Subjective vertigo . . . the patient himself moves in space.*



2



3

# TYPES OF VERTIGO:

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1. Simonton, K. M.: The Symptom of Dizziness, Arizona Med. *6*:28 (Sept.) 1949.

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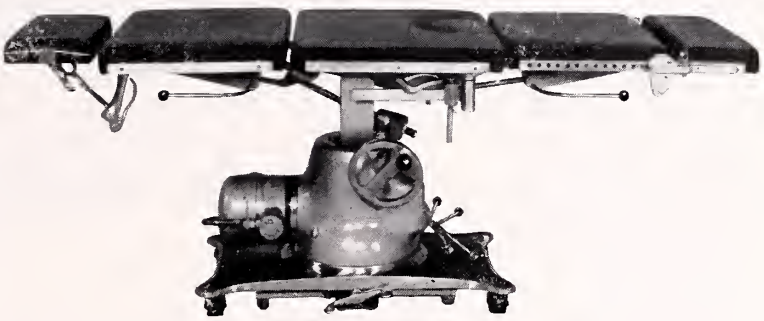
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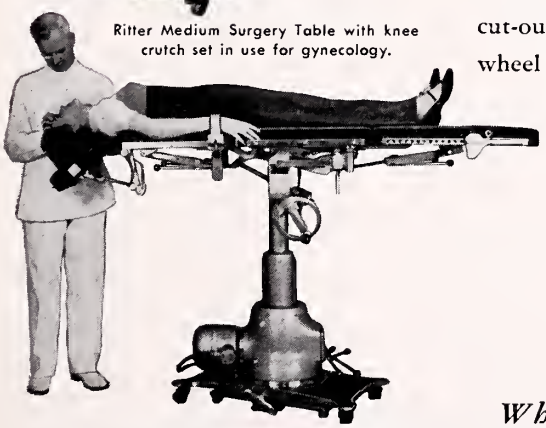


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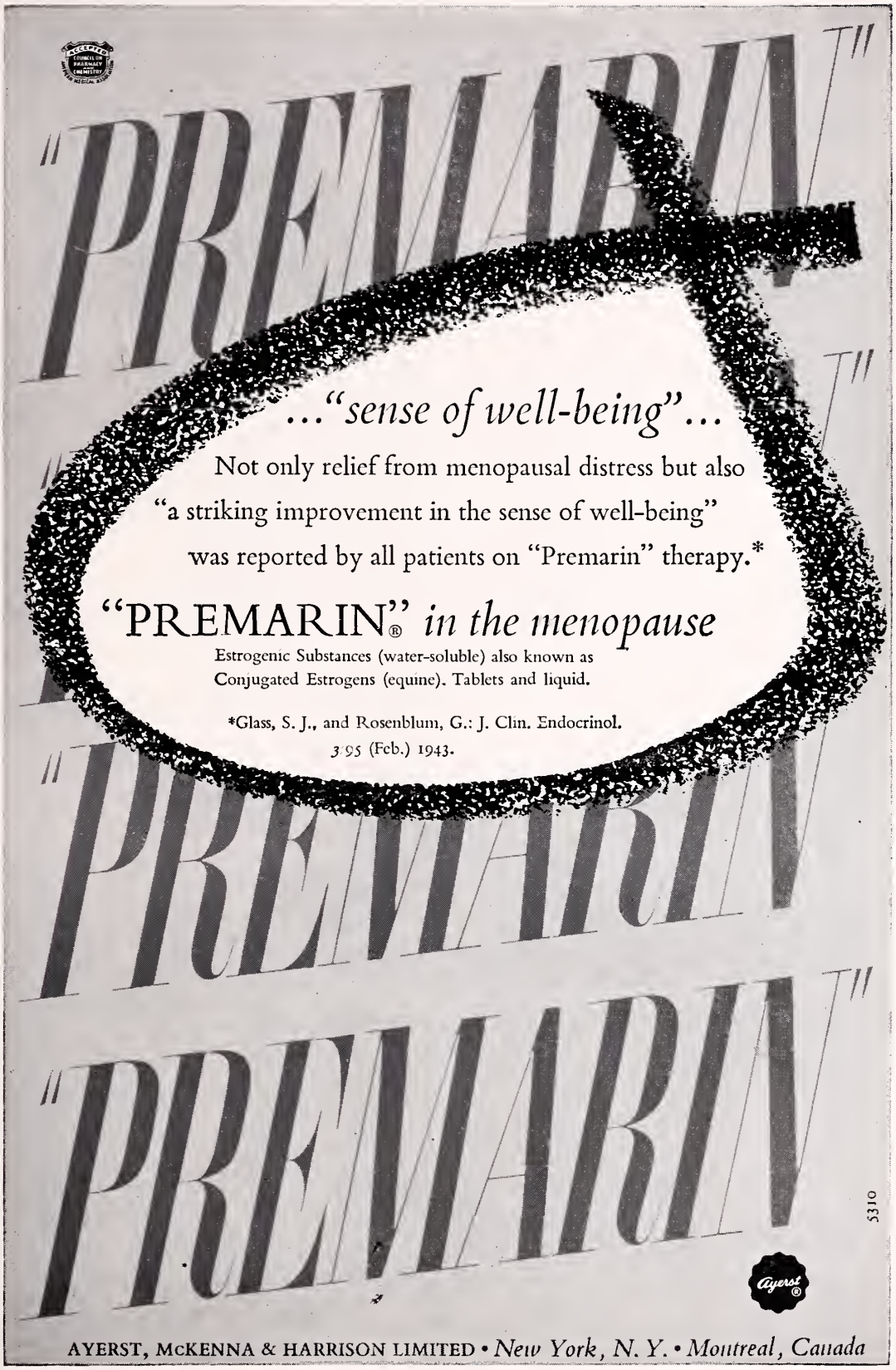
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*Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol.
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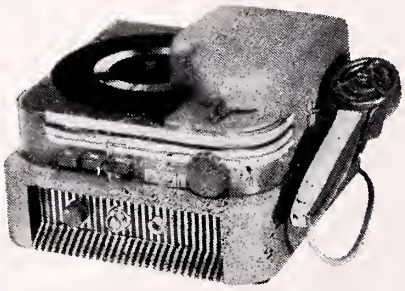
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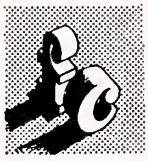
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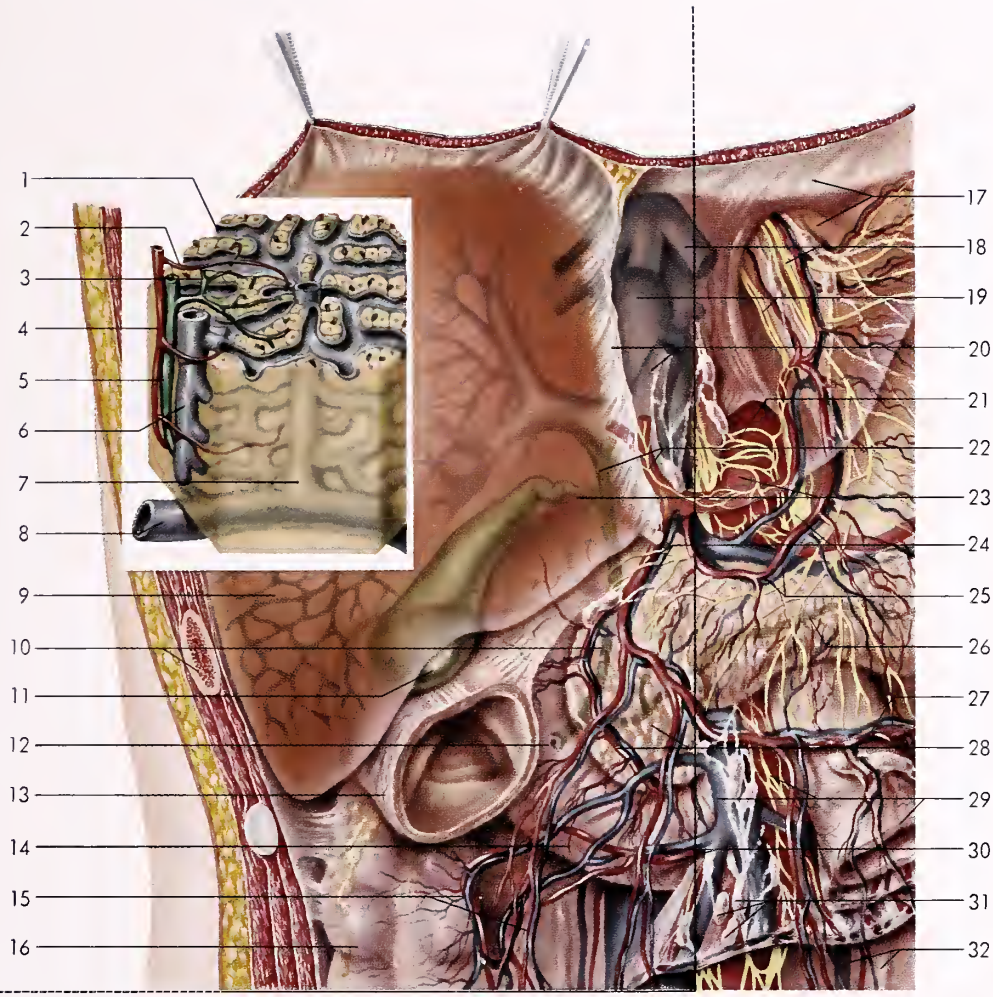
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# Upper Right Quadrant of the Abdomen




1 Sinusoid
2 Arteriole
3 Bile capillary
4 Branch of hepatic artery
5 Bile duct
6 Branch of portal vein
7 Central vein
8 Branch of inferior vena cava
9 Right lobe of liver
10 Common bile duct and tenth rib
11 Gallbladder
12 Papilla of Vater
13 Transverse colon
14 Duodenum
15 Branches of right colic artery and vein
16 Ascending colon
17 Coronary ligament and esophagus
18 Left hepatic vein and left vagus nerve
19 Inferior vena cava and right vagus nerve
20 Falciform ligament and branch of portal vein
21 Abdominal aorta and celiac plexus
22 Hepatic duct and hepatic artery
23 Cystic duct and celiac artery
24 Celiac ganglion and gastroduodenal artery and vein
25 Left gastric artery and coronary vein
26 Pancreatic duct
27 Right gastroepiploic artery and vein
28 Head of pancreas and pancreaticoduodenal artery and vein
29 Superior mesenteric artery and vein, and jejunum
30 Right colic artery and vein
31 Superior mesenteric lymph nodes
32 Inferior mesenteric vein and left ureter

*This is one of a series of paintings for Lederle by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.*

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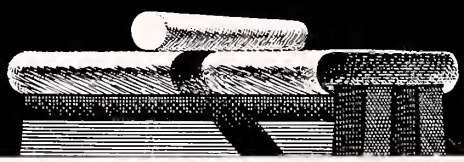
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| COBALT | 0.006 mg. | CHOLINE | 200 mg. |
| *COPPER | 0.7 mg. | FOLIC ACID | 0.05 mg. |
| FLUORINE | 3.0 mg. | *NIACIN | 6.7 mg. |
| *IODINE | 0.15 mg. | PANTOTHENIC ACID | 3.0 mg. |
| *IRON | 12 mg. | PYRIDOXINE | 0.6 mg. |
| MAGNESIUM | 120 mg. | *RIBOFLAVIN | 2.0 mg. |
| MANGANESE | 0.4 mg. | *THIAMINE | 1.2 mg. |
| *PHOSPHORUS | 940 mg. | *VITAMIN A | 3200 I.U. |
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| ZINC | 2.6 mg. | | |

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|---|---|
| *PROTEIN (biologically complete) | 32 Gm. |
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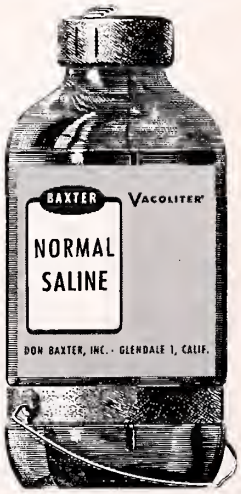


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impetigo



# skin infections and antibiotics



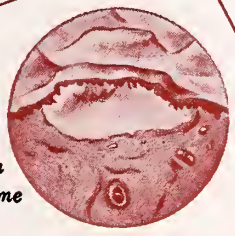
acne



pyoderma



folliculitis



erythema multiforme

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1. *Bednar, G. A.: South. M. J. 46:298 (March) 1953.*
2. *Wright, C. S. et al.: A. M. A. Arch. Dermat. & Syph. 67:125 (Feb.) 1953.*
3. *Robinson, H. M. et al.: South. M. J. (in press).*
4. *Andrews, G. C. et al.: J. A. M. A. 146:1107 (July 21) 1951.*


**Terramycin**

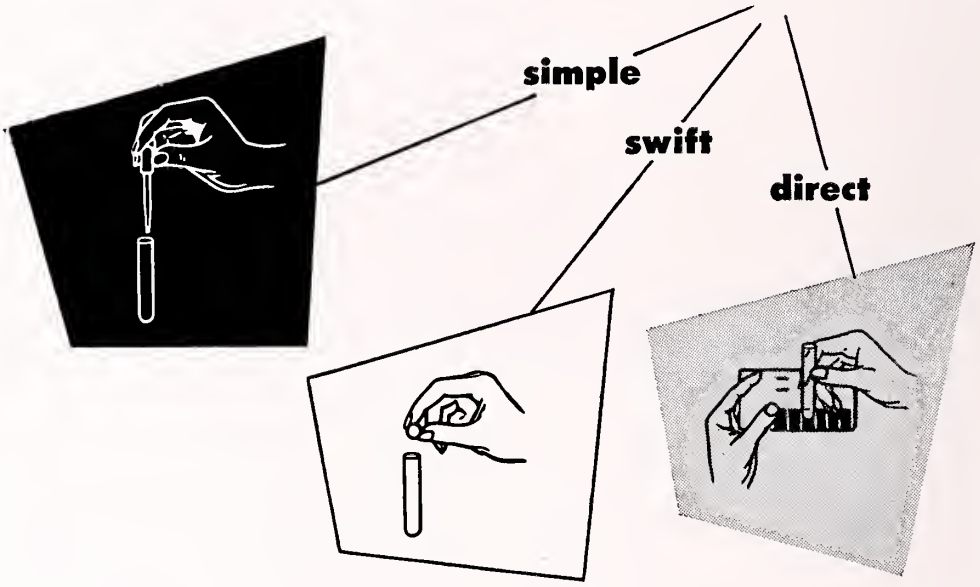
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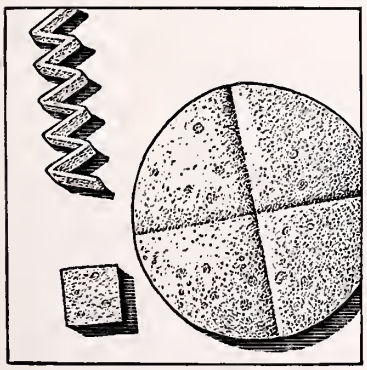
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1. Reich, W.J. et al. (1951), A Recent Advance in Estrogenic Therapy. I. Amer. J. Obst. & Gynec., 62:427, August. 2. Perloff, W.H. (1951), Treatment of the Menopause. II. Amer. J. Obst. & Gynec., 61:670, March. 3. Reich, W.J. et al. (1952), A Recent Advance in Estrogenic Therapy. II. Amer. J. Obst. & Gynec., 64:174, July.

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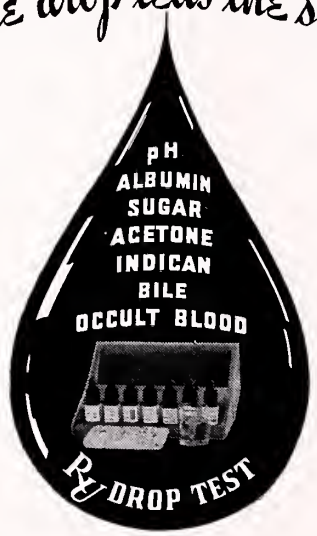
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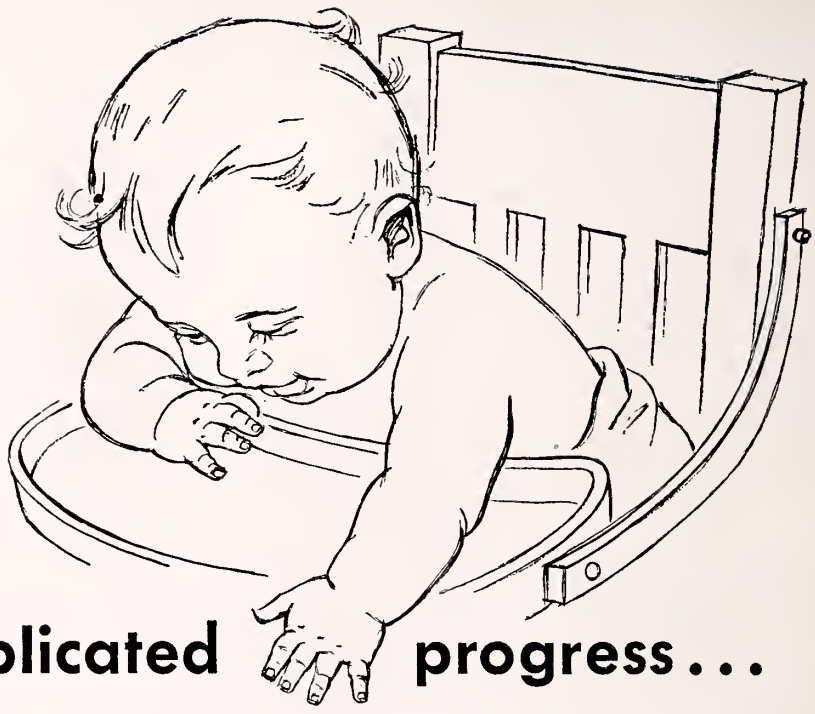


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1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592, 1951.




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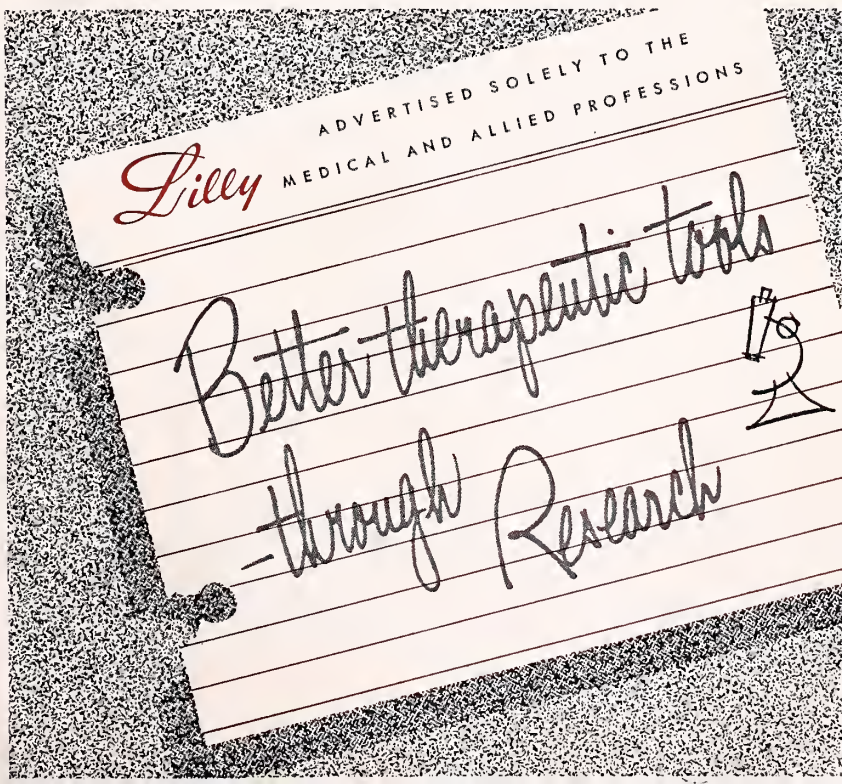
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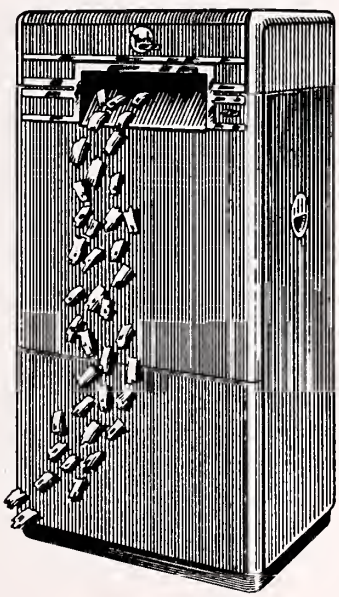
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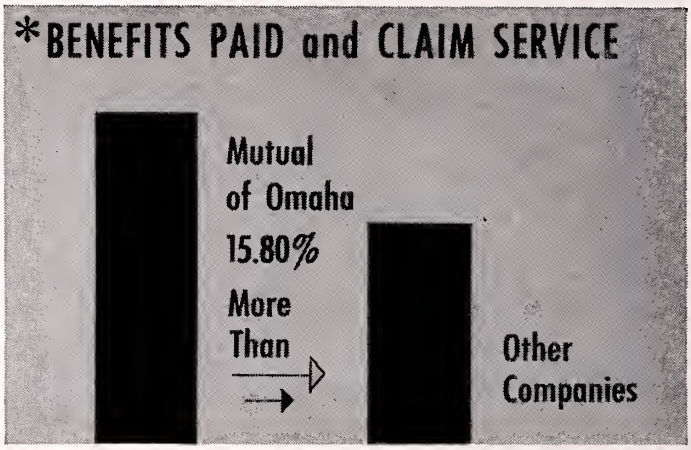
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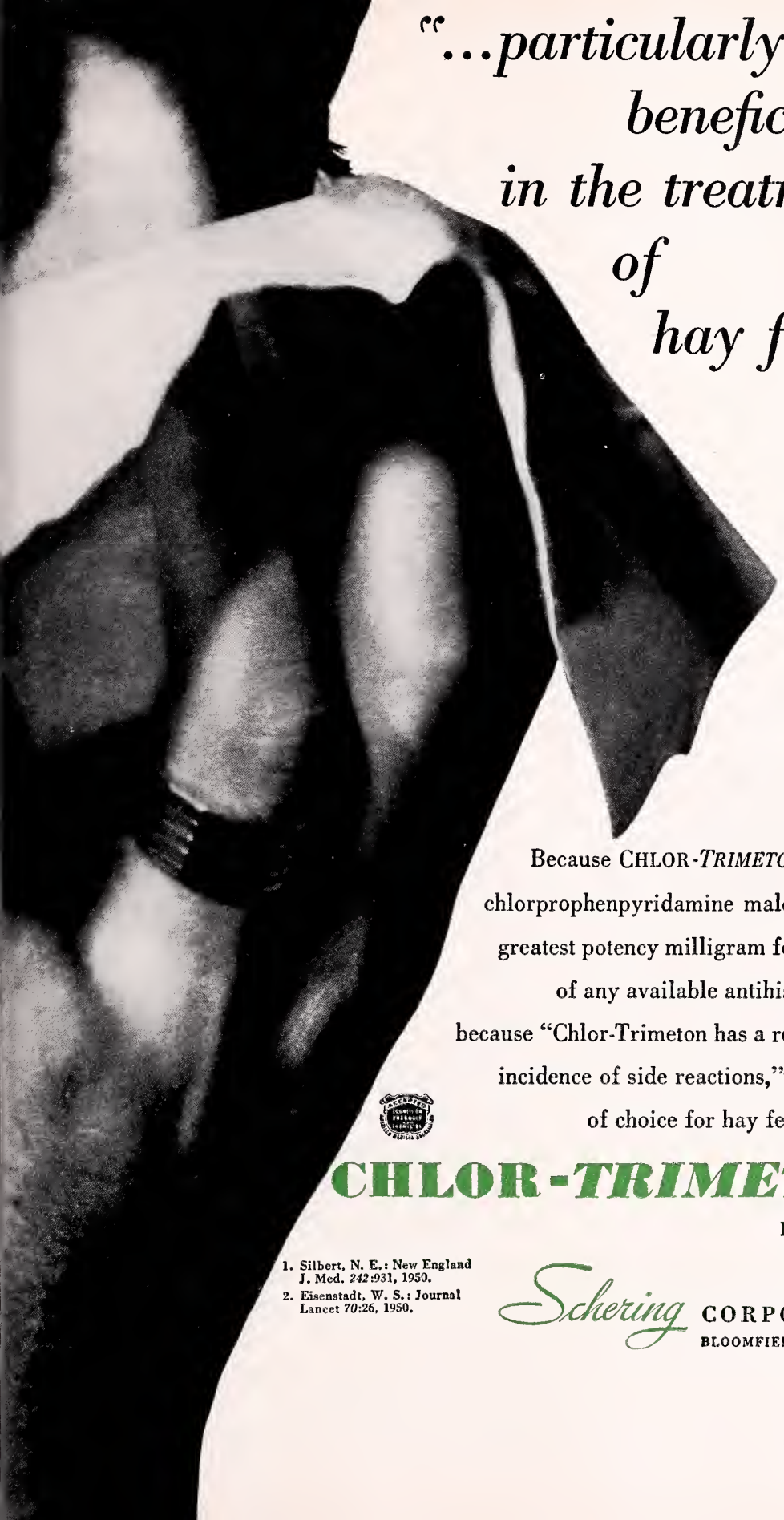
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1. Silbert, N. E.: New England J. Med. *242*:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet *70*:26, 1950.

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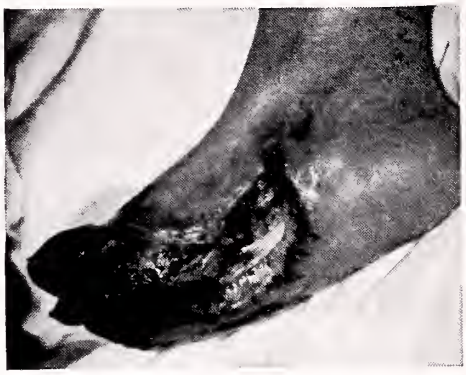
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*Literature on request*



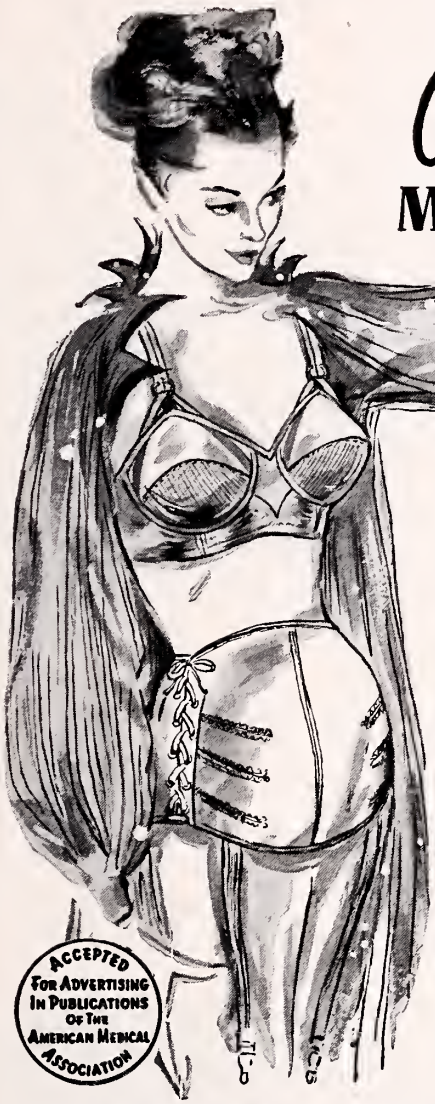

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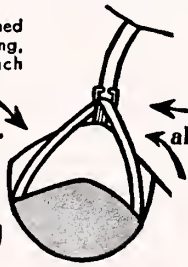
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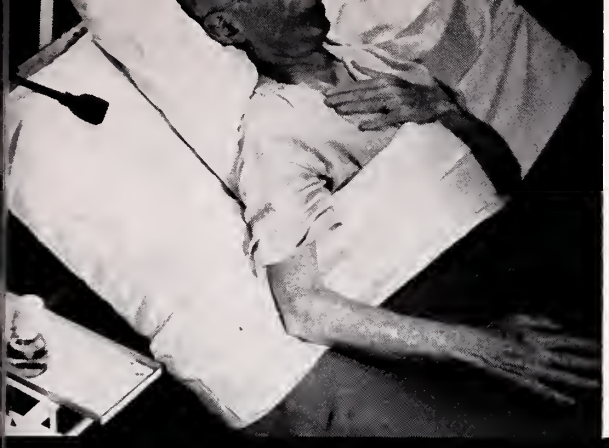
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1. Ferguson, C., and Miller, C. D.: J. Urol. *67*:762 (May) 1952.
2. Trafton, H. M., and Lind, H. E.: Ibid. *69*:315 (Feb.) 1953.
3. Blahey, P. R.: Canad. M. A. J. *66*:151 (Feb.) 1952.


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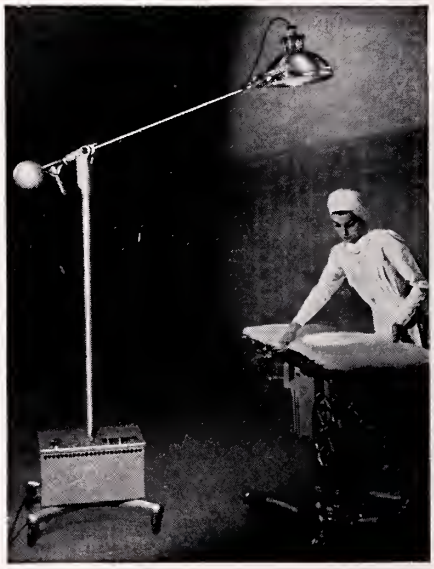
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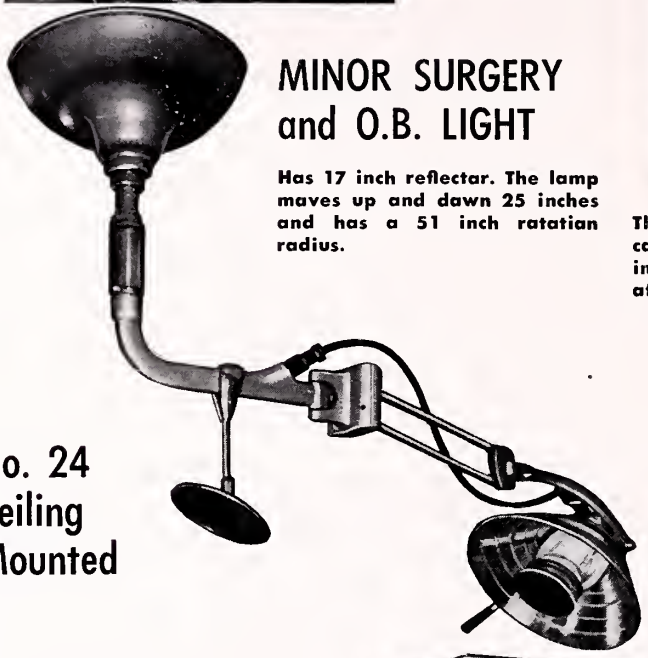
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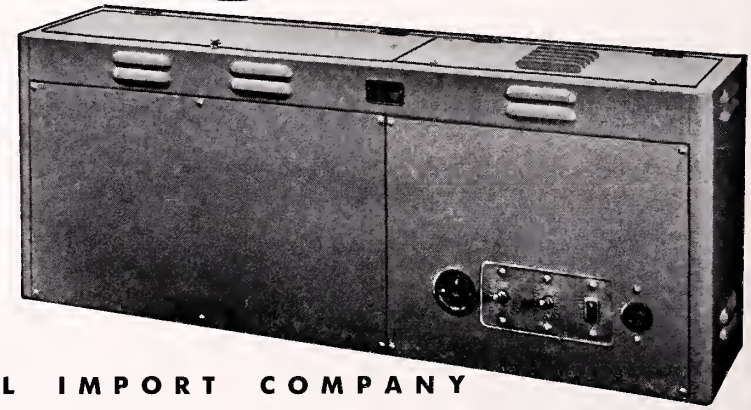
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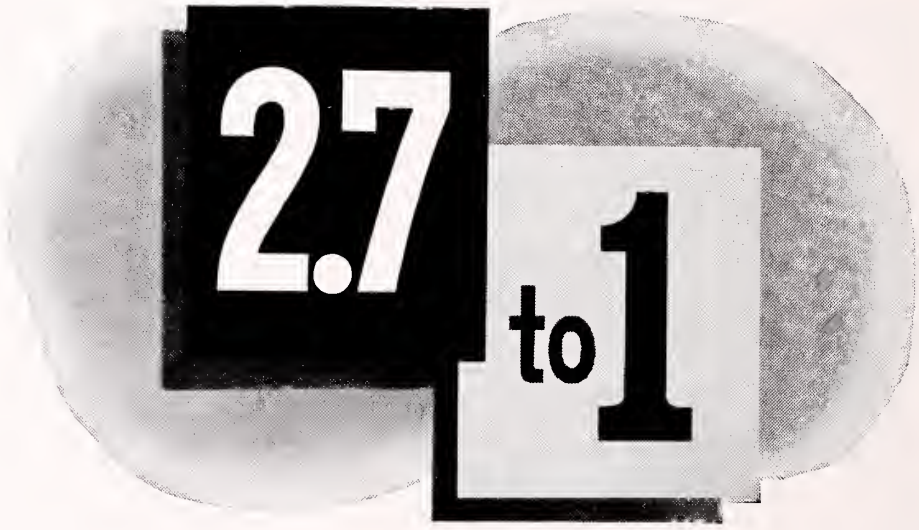

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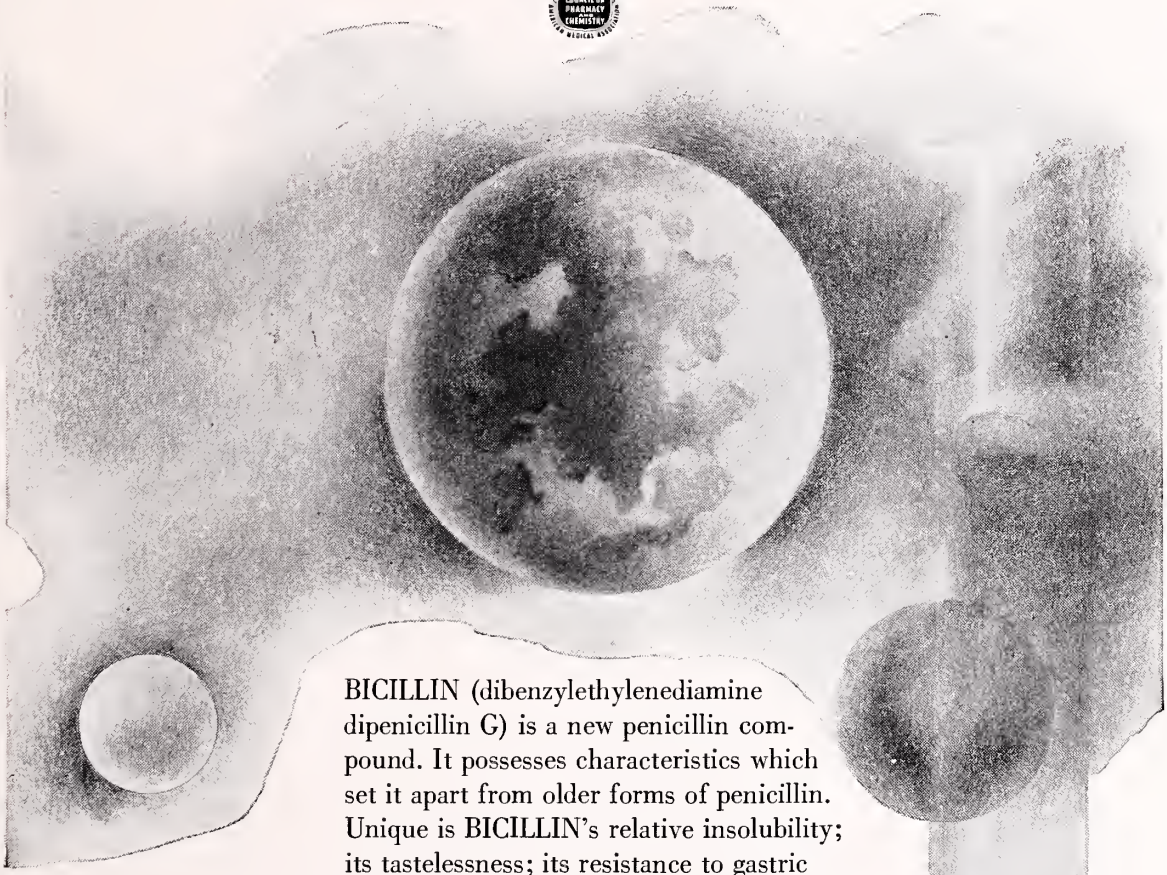
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# HUMAN INFESTATION WITH FASCIOLA GIGANTICA

GRANT N. STEMMERMANN, M.D.
HILO

AN INTERESTING clinical syndrome has recently been studied at the Hilo Memorial Hospital. It is caused by infestation with the liver fluke Fasciola gigantica, which is closely related to Fasciola hepatica. A brief resume of the historical, epidemiological, clinical and pathologic findings in this disease is being presented in order that knowledge of this condition may be disseminated to other island communities where it may be found.



DR. STEMMERMANN

The first cases within the territory were observed by Herbert[1] in the early years of this century. Alicata[1] has reviewed Herbert's cases and added several to bring the total number of cases to 18. All but one of the cases cited by Alicata were confirmed by the finding of a fluke. In each case Dr. Alicata felt that this fluke was Fasciola gigantica. One of the cases noted in his series occurred in a middle aged Japanese woman who died as a result of the effects of obstruction of the biliary tree by several mature flukes. This case was observed by the present writer.

Approximately nine years prior to her death this woman began to complain of bouts of severe epigastric pain, associated with eosinophilia, fever and flatulence. On one occasion a laparotomy was performed, and a granuloma was noted within the liver.

A review of the surgical specimen at the time of death revealed several interesting features which appeared to make this lesion a distinctive one. These changes included the finding of Charcot-Leyden crystals within a central zone of necrosis, a histiocytic form of granulation tissue and evidence of extensive repair. This seemed to indicate that fluke infestation in its early phases may give rise to a disease pattern which differs from the classic form characterized by biliary obstruction. Subsequently several additional patients were admitted to the Hilo Memorial Hospital who had complaints similar to those noted during the early phases of the first patient's disease. Laparotomy in these cases revealed the presence of identical granulomata.

### Epidemiology

An understanding of the disease pattern produced by fluke infestation can be obtained by a brief consideration of the life cycle of the parasite. Fasciola gigantica (Fig. 1) is naturally parasitic in cattle and swine[2]. It resides in the large hepatic ducts in the region of the porta hepatis (Fig. 2). Eggs are liberated into the gastro-intestinal system by way of the biliary ducts. After hatching they migrate to a snail. In the Hawaiian Islands the snail Fossaria ollula (Fig. 3) is the intermediate host. After further development within the snail, cercariae are liberated into fresh water. These encyst on aquatic vegetation. In the normal cycle, cattle are infected by eating this vegetation. Human beings are infected if they eat infested watercress. Larvae escape from the ingested cysts and penetrate the duodenal wall. They then cross the peritoneal space and penetrate the liver capsule.

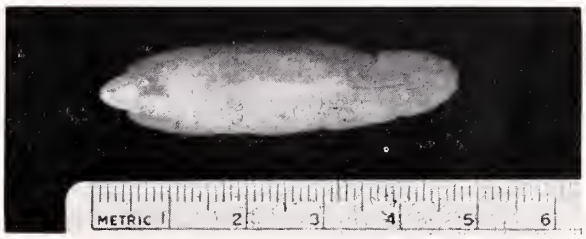



Fig. 1. Mature fluke, Fasciola gigantica

They then migrate through the liver parenchyma until a bile duct is reached. On entering these structures they pass downwards to the region of the porta hepatis. Eggs are produced as early as 77 days after infection. Certain differences have been noted in human infection as contrasted with bovine infestation. The mature fluke within the human usually does not produce eggs. In addition, migrating flukes and the granulomata produced by them are frequently extrahepatic.

The environmental conditions which are favorable to the continuation of the parasitic life cycle exist on the windward slopes of the Hawaiian Islands. Heavy rainfall, poor drainage and a mild climate make these regions suitable for snail production all year round and increase the longevity of fluke cysts on vegetation. Hilo and its surrounding countryside is an example of such

Read before the Sixty-Third Annual Meeting of the Hawaii Territorial Medical Association, Wailuku, Maui, May 2, 1953.

[1] Alicata, J. E.: Human Fascioliasis in the Hawaiian Islands, HAWAII MED. J. 12:196 (Jan.-Feb.) 1953.

[2] Alicata, J. E.: Observation on the Life History of Fasciola gigantica, the Common Liver Fluke of Cattle in Hawaii, and the Intermediate Host, Fossaria ollula. Hawaii Experimental Station, Honolulu, T. H., Bulletin No. 20, August, 1938.

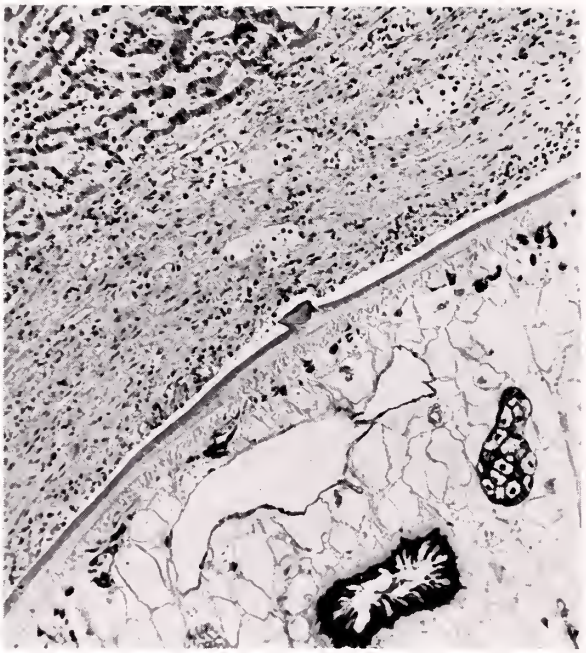


Fig. 2. Mature fluke within hepatic duct, x100. H&E.

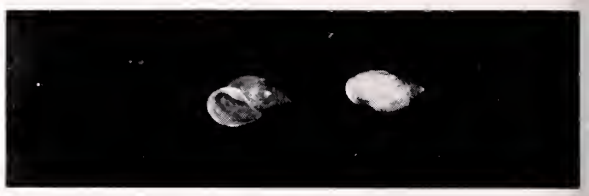


Fig. 3. Intermediate host, Fossaria ollula.

an environment. Many cattle are grazed on the hills overlooking the city. The grazing areas receive an average annual rainfall of 200 inches. Eighty per cent of the cattle in this region are fluke-infested. The sluggish streams draining the area are favored by the growers of watercress. One such patch was found to be heavily infested with snails, of which 5 per cent were infected. It is estimated that this one patch furnished the Hilo market with 35 pounds of watercress each day. In view of the fact that cattle are permitted to range in the same drainage areas used for the production of watercress, it is less surprising that human infestation occurs, than that so few cases have been discovered. It is likely that, since man is not a natural host to Fasciola gigantica, abortive infestations may occur. There appears to be a definite clinical pattern associated with the migratory phase of Fasciola gigantica infestation. This pattern consists of intermittent bouts of fever and upper abdominal pain, associated with eosinophilia.

### Symptoms

Pain is the most prominent symptom and is centered in the epigastrium or in the right upper quadrant. It is also occasionally noted in the chest. It has been found to radiate to the chest, to the back and to the lower quadrants. Patients describe the pain as wave-like, cramp-like, or burning. It may be made more severe with coughing. This is probably due to irritation of the inflamed diaphragmatic peritoneum. The pain may be associated with abdominal tenderness over the epigastrium and upper quadrants. It usually appears suddenly, lasts a few hours and disappears abruptly. Some patients associate the pain with ingestion of fatty foods, but this is inconstant.

Fever is noted during attacks of pain. It may vary from 100 to 105° F. It has a tendency to subside gradually, returning to normal within twenty-four hours after an attack. The fever and pain are frequently associated with profuse sweating. Most cases also complain of nausea or vomiting or both. Jaundice is not to be expected during the migratory phase of the disease unless it is associated with extensive liver damage. A history of early jaundice was noted in only one of 14 cases reviewed by the author[3].

The most spectacular clinical finding, when it occurs, is that of a migrating subcutaneous mass. This has been noted on two occasions. Non-migrating subcutaneous masses occur more frequently. Intact flukes may or may not be found within these subcutaneous masses. These tumors are granulomata which on histological examination are similar in appearance to those noted within the liver. The migrating fluke may occasionally be coughed from the respiratory tract.

### Laboratory Findings

Eosinophilia is constant during the migrating phases and may vary from 24% to 60%. During the first attacks the count may be low, reaching its highest levels after several months. A slight degree of albuminuria may be noted. Usually no Fasciola eggs will be noted in the stools. During the migratory phases the parasites have not reached their sites of egg production. When they reach the bile ducts they are not likely to produce eggs in the human.

### Progress of Disease

The group of findings noted above may occur over months and years. The epigastric pain may persist after the removal of a distant subcutaneous mass, probably indicating that other granulomata are also present within the epigastrium. The pattern described above is reproduced in each attack. As the case is followed, the attacks become less numerous and less severe. For example, one pa-

[3] Stemmermann, G. N.: Human Infestation with Fasciola gigantica, Am. J. Path. (in press).

tient was first seen at the age of 16 years. She had many attacks, similar to those described above, at intervals of from four to ten days, over a period of approximately four months. She was then symptom-free for four years. At this time the entire chain of symptoms recurred. During one attack she coughed up an intact fluke. She continued to have attacks of epigastric pain after this event for four more years. Since 1946 she has had a well defined area of calcification within the liver, which probably represents a calcifying granuloma. This general pattern is typical of the cases seen by the writer.

### Pathology

Granulomas associated with fluke infestation have been noted by the writer in the liver, the tail of the pancreas, and the subcutaneous fat. They have a soft, yellowish brown center which has a pasty consistency. Recent lesions have an irregular outer margin and are fluctuant (Fig. 4). Older lesions are encapsulated and resemble old, caseous, tuberculous foci (Fig. 5). They consist of a central zone of necrotic tissue containing many nuclear fragments and Charcot-Leyden crystals. In animal experiments conducted by the writer[3], it was noted that a wide border of intact, but necrotic tissue borders the viable parasites. This implies that the parasite elaborates a toxin which causes an infarct-like necrosis. During later phases the necrotic tissue undergoes liquefaction and loses its structural integrity. The zone of necrosis is surrounded by granulation tissue which varies in thickness according to the stage of healing. It is thickest in older cases and in cases of long duration. The granulomata vary from 1 cm. to 6 cm. in diameter.

During the hepatobiliary phase of the disease the parasite causes tissue changes due to direct action on host tissue and to obstruction of the biliary tree. Diffuse suppurative cholangitis with abscess formation may occur in the presence of secondary infection. When resident within the bile ducts, the parasite subsists chiefly on bile duct epithelium and leukocytes. It is usually separated from the mesenchymal tissues of the host by an intact epithelium. The bile duct may contain sinuses which extend from the surface to the deeper tissues and are usually lined by epithelium. Histiocytes, neutrophils, lymphocytes and plasma cells are noted within the underlying tissue. Local tissue necrosis and granuloma formation are not noted during this phase. The difference between the tissue reactions noted during migration and adjacent to the mature fluke in its proper habitation stems from the fact that migrating flukes are in intimate contact with host tissue. Tissue necrosis due to



Fig. 4. Recent granuloma, gluteal fat, x40.

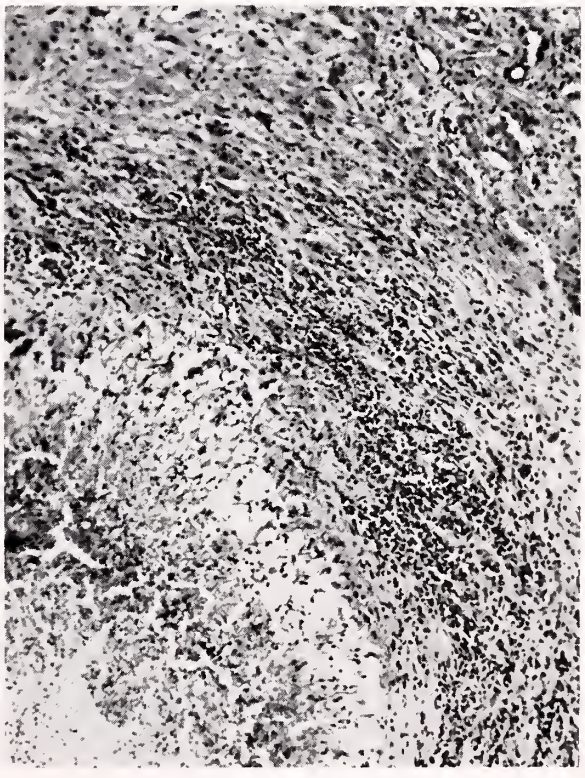


Fig. 5. Old granuloma, liver, x100.

excreted toxin and due to sensitivity to the proteins and polysaccharides of the disintegrating fluke bodies must elicit a response within the host tissues. This probably accounts for the clinical syndrome noted during the migratory phase of the disease.

### Differential Diagnosis

Most of the patients noted by the writer have been felt, at one time or another, to have cholecystitis. The localization of the pain in these cases, associated with upper quadrant tenderness, accounts for this finding. A suspicion of fluke infestation may be entertained in any case presenting the symptoms of cholecystitis, but associated with eosinophilia, fever, and a history of watercress ingestion. In one case the diagnosis of fluke granuloma was made in the presence of a known chronic cholecystitis. The diagnosis was confirmed at laparotomy when such a granuloma was noted in the tail of the pancreas. A careful search for granulomata of the liver or its adjacent tissues should be made if an operation for recurring cholecystitis reveals the gallbladder to be normal.

Symptoms almost identical to those noted during the migratory phase of Fasciola infestation may be noted during similar phases of other parasitic life cycles. This is particularly true of parasites not usually noted in man. One such disease is noted among young children who have been infected with dog or cat ascarids. These children give a history of having eaten dirt. The diagnosis in such a case will depend upon an accurate history and the age of the patient. Occasional aberrant human ascarid infestations may also produce epigastric granuloma similar to those noted in these cases. Often the ascarid parasites may be noted within the granulomata, thus establishing a diagnosis.

### Skin Testing

In order to obtain better diagnostic accuracy, Alicata has prepared a skin testing antigen from Fasciola gigantica. The writer has used this material in testing a selected group of patients, too few, however, to properly evaluate its reliability or establish a correct test dose. Positive tests have been obtained among the survivors of one of our deceased patients. In addition, a positive result has been obtained in one case of granuloma. A negative test was obtained in a young woman who coughed up a liver fluke six years prior to testing. More work on this material must be performed before it can be properly evaluated.

### Prognosis and Treatment

Few patients die because of Fasciola gigantica infestation. Only 2 fatal cases were noted among the 21 cases listed in the combined studies of Alicata[1] and the writer[3]. When death does occur, it is usually the result of prolonged biliary obstruction with secondary infection of the dilated duct system. Symptoms of obstruction usually force patients to a physician before great mischief is done. Exploration of the duct system with removal of the offending flukes is then possible. During the early migratory phases chances of a fatal termination are remote, although unpleasant and uncomfortable attacks may occur. Aside from the disabling pain, the wandering parasite may disorder several visceral systems in its wanderings.

If the chest and lung are invaded, pleural effusion and cough may occur. If the fluke dies, the resulting granuloma may cause lingering recurrent discomfort at its site. In most cases the granuloma will give no other offense than this. Treatment at this stage may depend upon the site of the lesion and the degree of discomfort of the patient. Subcutaneous lesions are easily removed by block dissection. Most epigastric lesions probably resolve and may be handled expectantly, unless a definitely assured diagnosis is urgent. In these cases careful search of the liver, the pancreas, and the peripancreatic tissues may be indicated. If the lesion is large, it would seem a needless risk to remove it from a vital area if it does not impair function. A segment of its wall is sufficient for histologic diagnosis. If an expectant plan of therapy is followed, the physician must be on the watch for the development of biliary disease.

### Summary

1. The parasite Fasciola gigantica, a liver fluke, has been found to infect man.

2. Infestation is usually derived from the ingestion of infected watercress.

3. Migratory and hepatobiliary phases of the disease occur. The former is marked by the production of granulomata, often in aberrant locations. In addition, mature flukes may be recovered at the aberrant sites.

4. The symptoms of the migratory phase are sufficiently typical to enable a clinical diagnosis. These consist of intermittent bouts of intense abdominal pain, fever, nausea and vomiting. These symptoms are associated with eosinophilia. They may be associated with the formation of subcutaneous masses which may be seen to migrate.

### Acknowledgment

The author wishes to thank Dr. J. E. Alicata for his kind advice in the preparation of this paper and for furnishing the illustrations of the gross fluke and its intermediate host. Thanks are also due Dr. I. L. Tilden for furnishing the photomicrographs of the histologic material.

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# FURTHER STUDIES IN PRIMIPAROUS LABORS AT KAPIOLANI HOSPITAL

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HONOLULU

IN 1950, the writer[1] studied a series of 1175 primiparous labors which occurred in the Kapiolani Maternity and Gynecological Hospital in the year 1949. The statement is heard occasionally that obstetrical complications are greatly increased by the mating of Caucasian males to Oriental females, most of whom have pelves which would be classified by Occidental measurements as justo minor. Since these remarks are concerned with data obtained in Hawaii and from patients delivered here, the term Oriental applies in the main to those of Japanese, Chinese, Korean, or Filipino ancestry.

It has been particularly interesting to study the matings of the Oriental female with the Occidental male. Since most of the Orientals in Hawaii are of Japanese extraction, it follows that most of the cross breeding is concerned with Japanese mothers and Caucasian fathers. As the original studies included only 22 Japanese mothers mated to Caucasians, it was felt that the results of the study in so small a group would be misleading. Accordingly, all primiparous labors at the Kapiolani Hospital of Oriental mothers mated to Caucasian fathers in the years 1946 to 1948, and 1950 to 1952, inclusive, were reviewed and added to the 1949 series. This brings the number of this group of matings studied to a total of 190 in the years 1946 to 1952, inclusive. A few more Caucasian female and Oriental male matings were also included in the study.

The various matings of Oriental females with Caucasian males were distributed as shown in Table 1.

TABLE 1. *Numbers of 4 Varieties of Oriental-Caucasian Matings.*

| MALES | | FEMALES | |
|---|---|---|---|
| Caucasian | × | Japanese | 174 |
| | | Chinese | 20 |
| | | Korean | 16 |
| | | Filipina | 15 |
| | | TOTAL Oriental | 190 |

The Japanese female × Caucasian male series is the only one of any statistical value and that figure of 174 cases is admittedly small.

Those readers outside of the Territory of Hawaii may well ask the question, "What about the Hawaiian × Caucasian crosses?" Hence, a short clarification of our Island population status is in order. The original population consisted of Polynesians who migrated here from Tahiti and Samoa for the most part, and came to be known as Hawaiians. Occasional Europeans and Asiatics, and a few Melanesians (Papua, New Guinea, etc.) gradually drifted in by the ship-jumping or shipwreck routes and were absorbed. However, until the visits of Captain Cook in 1778, and Vancouver in 1792, Hawaiians were a fairly pure strain of Polynesians.



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A succession of events has changed this. The influx of whaling ships with European and American crews, and subsequently the importation of large numbers of Chinese, Japanese, Puerto Ricans, Portuguese, and Filipinos for work in the sugar and pineapple industries have altered the picture. The mixing of Polynesians and Caucasians took place so long ago and so completely that there is little or no material left today for study of the "full-blood" Hawaiian female mated to the Caucasian male. In addition, syphilis, measles, tuberculosis and many other diseases, to which Polynesians succumbed by the thousands, decimated the native population, much as happened with the American Indians. This resulted in a rapid shift to a polyglot population. The recent World War with the tremendous influx of armed forces and defense workers has also played a part in population adjustment.

The ethnic distribution of the 1175 primiparas studied at the Kapiolani Maternity Hospital in 1950 is shown in Table 2.

TABLE 2. *Ethnic Distribution of 1175 Primiparas Studied.*

| RACE | NO. | PER CENT |
|---|---|---|
| Japanese | 473 | 40.2 |
| Caucasian | 282 | 24 |
| Part-Hawaiian | 173 | 14.9 |
| Chinese | 148 | 12.6 |
| Filipina | 48 | 3.4 |
| Korean | 19 | 1.6 |
| Hawaiian | 10 | 0.8 |
| Miscellaneous | 22 | 1.9 |

The Part-Hawaiian group contains all sorts of combinations of individuals bearing large to very

Read before the Sixty-Third Annual Meeting of the Hawaii Territorial Medical Association, Wailuku, Maui, May 2, 1953.

[1] Bowles, H. E.: An Analysis of 1175 Primiparous Labors in Kapiolani Hospital for the Year 1949, Proc. Staff Meet. Straub Clin. 16:120 (Aug.) 1950.

dilute proportions of Hawaiian blood. The group labeled "miscellaneous" contains a variety of mixtures of non-Hawaiians and contains two negresses. Only three babies out of the entire series were born of "full-blood Hawaiian" parents, and there is good cause to wonder whether there really are any Hawaiians at the present time whose germ plasm is of undiluted Polynesian content. This must be left to the anthropologists to answer.

Revising the tables of the primiparas studied to include the additional hybrid matings in the years under consideration, the following results were obtained (Table 3):

TABLE 3. *Term Weight Averages of Various Combinations.*

| MOTHER | FATHER | CASES | AV. WEIGHT |
|---|---|---|---|
| Japanese | Japanese | 395 | 7 lb. 8 oz. |
| Caucasian | Caucasian | 197 | 7 lb. 6 oz. |
| Japanese | Caucasian | 174 | 7 lb. 5 oz. |
| Part-Hawaiian | All combinations | 158 | 7 lb. 7 oz. |
| Chinese | Chinese | 134 | 6 lb. 15 oz. |
| Filipina | Filipino | 31 | 6 lb. 11 oz. |
| Caucasian | Oriental (Chinese, Japanese, Korean, Filipino) | 30 | 7 lb. 2 oz. |
| Mixture | Mixture | 22 | 7 lb. 1 oz. |
| Chinese | Caucasian | 19 | 7 lb. 2 oz. |
| Filipina | Caucasian | 18 | 6 lb. 15 oz. |
| German War Brides | Oriental (Chinese, Japanese, Korean) | 12 | 7 lb. 2 oz. |
| Korean | Caucasian | 10 | 7 lb. 7 oz. |

From item 6 on, the number of cases is so small as to be of little value. They are included, however, for the sake of completeness.

TABLE 4. *Length of Combined First and Second Stages of Labor.**

A. Vertex term** deliveries.

| MOTHER | FATHER | CASES | HOURS DURATION |
|---|---|---|---|
| Japanese | Japanese | 316 | 14 hrs. 25 min. |
| Caucasian | Caucasian | 210 | 15 hrs. 50 min. |
| Japanese | Caucasian | 164 | 13 hrs. 40 min. |
| Part-Hawaiian | All combinations | 157 | 14 hrs. 8 min. |
| Chinese | Chinese | 126 | 12 hrs. 6 min. |
| Filipina | Filipino | 28 | 12 hrs. |
| Caucasian | Oriental*** | 27 | 17 hrs. 50 min. |
| Filipina | Caucasian | 16 | 9 hrs. 23 min. |
| German War Brides | Oriental*** | 12 | 8 hrs. 3 min. |
| Korean | Korean | 6 | 11 hrs. 4 min. |

* Some error may, of course, exist as it is difficult to state accurately when a labor commences. It is even more difficult in breech than in vertex deliveries.

** Term delivery using accepted standard means baby weighed over 5 pounds, 8 ounces. (Question: "Is it acceptable to use Occidental figures for Oriental patients?" This is beyond the province of this paper.)

*** Chinese, Japanese or Korean.

B. Breech labors term series, 41 cases; averaged 10 hours, 22 minutes. Series too small to break down into groups.

In order to determine whether the Island born and reared Caucasian population had any lower incidence of abnormal labors than the Caucasians of mainland origin, the group of Caucasian women with Caucasian mates was further broken down. By way of explanation, there is a minimal incidence of rickets here, and there is the general impression that the all year round outdoor life predisposes to easier and shorter labors. Hence, the following groups were studied:

TABLE 5. *Duration of Labor among Island-born Caucasian Mothers with Caucasian Husbands.*

| MOTHER | FATHER | CASES | STAGES I & II HOURS LABOR |
|---|---|---|---|
| Caucasian (mainlanders) | Caucasian | 165 | 14 hrs. 20 min. |
| Caucasian (native of Hawaii) | Caucasian | 43 | 13 hrs. 8 min. |
| Caucasian (Portuguese) | Caucasian (Portuguese) | 19 | 15 hrs. 9 min. |

TABLE 6. *Incidence of Prematurity* (Entire Series). (Excluding twins)*

| MOTHER | FATHER | PER CENT |
|---|---|---|
| Filipina | Filipino 3:35 | 8.5 |
| Caucasian (excluding Portuguese) | Caucasian (excluding Portuguese) 14:211 | 6.6 |
| Chinese | Chinese 9:148 | 6.0 |
| Part-Hawaiian | All combinations 9:173 | 5.2 |
| Japanese | Japanese 15:415 | 3.6 |
| Chinese | All combinations 1:39 | 2.5 |
| Japanese | Caucasian 4:165 | 2.4 |
| Japanese | All combinations 0:58 | 0.0 |
| Mixed (excluding Part-Hawaiian) | All combinations 0:22 | 0.0 |
| German War Brides | Oriental (Chinese, Japanese, Korean) 0:12 | 0.0 |
| Portuguese | Portuguese | 0.0 |

* Any baby weighing 5 pounds, 8 ounces, or under is classified as a premature in Hawaii. If possible, it might be proper to work out a standard that would allow for racial differences. This would seem impossible in the mixed group due to multiplicity of combinations.

TABLE 7. *Incidence of Twins.*

| MOTHER | FATHER | NO. OF SETS |
|---|---|---|
| Japanese | Japanese | 0:415 |
| Caucasian (minus Portuguese) | Caucasian (minus Portuguese) | 1:211 |
| Japanese | Caucasian | 1:165 |
| Part-Hawaiian | All combinations | 1:173 |
| Chinese | Chinese | 0:167 |
| Japanese | All combinations (except Caucasian) | 0:58 |
| Korean | All combinations (except Caucasian) | 0:42 |
| Chinese | All combinations (except Caucasian) | 0:39 |
| Filipina | Filipino | 0:35 |
| Caucasian | Oriental (Japanese, Chinese, Korean) | 0:32 |
| Portuguese | Portuguese | 0:20 |

TABLE 8. *Incidence of Combined Term Stillbirths and Neonatal Deaths.*

| MOTHER | FATHER | RATIO | PER CENT |
|---|---|---|---|
| Filipina | Caucasian | 1:15 | 6.6 |
| Korean | Caucasian | 1:16 | 6.3 |
| Chinese | Chinese | 2:134 | 1.4 |
| Japanese | Japanese | 5:415 | 1.2 |
| Japanese | Caucasian | 1:165 | 0.05 |
| Part-Hawaiian | All combinations | 1:158 | 0.04 |
| Caucasian | Caucasian | 1:231 | 0.04 |
| Caucasian | Oriental (Japanese, Korean, Chinese, Filipino) | 0:30 | 0.0 |
| Filipina | Filipino | 0:31 | 0.0 |
| Chinese | Caucasian | 0:19 | 0.0 |
| Mixture | Mixture | 0:22 | 0.0 |
| German War Brides | Oriental (Japanese, Korean, Chinese, Filipino) | 0:12 | 0.0 |
| Hawaiian | All combinations | 0:9 | 0.0 |

TABLE 9. *Cesarean Sections were Distributed as Follows: (In the 1473 Deliveries)*

| MOTHER | FATHER | RATIO | PER CENT |
|---|---|---|---|
| Chinese | Caucasian | 3:20 | 15.0 |
| Japanese | Japanese | 30:415 | 7.2 |
| Korean | Caucasian | 1:16 | 6.3 |
| Filipina | Caucasian | 1:16 | 6.3 |
| Part-Hawaiian | All combinations | 6:173 | 3.4 |
| Portuguese | Portuguese | 1:20 | 5.0 |
| Caucasian (non-Portuguese) | Caucasian (non-Portuguese) | 9:211 | 4.2 |
| Filipina | Filipino | 1:35 | 2.8 |
| Chinese | Chinese | 4:134 | 2.2 |
| Miscellaneous | Miscellaneous | 0:22 | 0.0 |
| German War Brides | Oriental (Japanese, Korean, Chinese, Filipino) | 0:12 | 0.0 |
| Caucasian | Oriental (Japanese, Chinese, Korean, Filipino) | 0:32 | 0.0 |

## Discussion

An unusual opportunity presents itself in Hawaii for a study of the mixing of peoples of many lands. It was felt of sufficient interest to justify comparative analysis as to the incidence of complications of labor and delivery, and duration of labor in a group of primiparas. Due to the commonly held idea that the women of the Far East with their justo minor (as judged by American or European standards) pelves are prone to run into trouble when they mate with Caucasian males, it was felt that this group was particularly interesting. Some of the figures are, of course, of virtually no value, as too few cases are included in that particular combination. Prior to World War II, the matings between Orientals and Caucasians were too infrequent for any study such as the foregoing.

In Table 2, it will be noted that the average term weight of 393 full-term Japanese babies was 7 pounds, 8 ounces, as compared to 7 pounds, 7 ounces for 157 Part-Hawaiian babies and 7 pounds, 6 ounces for 197 Caucasian babies. One hundred seventy-four full-term babies of Japanese mothers and Caucasian fathers averaged 7 pounds, 5 ounces. Even though the numbers studied are not large, one would offhand expect the term babies of Japanese mothers and fathers to be smaller than the pure Caucasian babies.

There was no significant difference in the duration of primiparous term labors in the "full blood" Japanese, "full blood" Caucasian and in the crossmatings of Japanese females and Caucasian males. The labors of Filipinas and Chinese (unmixed matings) tended to be shorter than the groups just mentioned. Prematures were found oftenest among the Filipinos, Caucasians, Chinese and Part-Hawaiians.

Twinning was so scarce that the figures probably are without value. Stillbirths and neonatal deaths were scarce in general, and the full-blood Japanese and full-blood Chinese showed the highest rates. The highest cesarean section rate occurred in the Japanese mother and Japanese father group (7.2%); the Japanese mother and Caucasian father group (6.0%); and the non-Portuguese Caucasian group (4.2%). Why should the section rate in the Japanese mothers be higher than in the other groups whether the women were mated to Japanese or Caucasian men, and why are their babies larger? They seem definitely larger than the Chinese babies of Hawaii (See Tables).

Most of the Chinese residents in Hawaii are from South China and tend toward shorter stature than do the Northern Chinese. No statistics are at hand in regard to comparative birth weights of full-term babies of the North and South China group nor of the Japanese in Japan. Most of Hawaii's Japanese are from the mainland of Japan, especially Hiroshima and Yamaguchi prefectures. There is no great difference in size of the adult Japanese throughout the length and breadth of Japan comparable to the differences that may be noted in China. Included in the Japanese group are also many individuals from Okinawa (Loo Choo [Ryukyu] Islands). These people tend toward small stature and show some physical and cultural characteristics that would place them apart anthropologically from the mainland Japanese. However, it is virtually impossible to subdivide the Japanese group here in Hawaii. It should be borne in mind that many Japanese carry a strong strain of Ainu blood. The Ainu are a proto-Caucasian people of whom a few are left in the Northern Islands of Japan. They originated in Siberia. This explains in part the higher incidence of Rh negative blood in Japanese women as compared with the more homogeneous Chinese group. From the data obtained in these studies, it would seem that an Oriental girl mated to a Caucasian male is not headed for obstetrical trouble any oftener than the Japanese woman mated to a husband of her own people.

It is to be hoped that the foregoing studies may be a stimulus to further work along these lines.

## Summary

One thousand four hundred seventy-three primiparous labors which occurred in the Kapiolani Maternity Hospital, Honolulu, have been reviewed with regard to term birth weights of the babies, duration of labors, the incidence of prematurity, term stillbirths and neonatal deaths, and cesarean sections in the different ethnic groups. Particular interest is expressed in the group of Oriental females mated to Caucasians. In the group studied, there seem to be more hazards encountered in the Japanese women mated to Japanese males than occurred in other combinations. This is contrary to the concept generally held.

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# HARADA'S DISEASE -- VOGT-KOYANAGI SYNDROME

## DIFFUSE MELANITIS

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THE SYNDROME to be described and illustrated by case reports represents a rare entity with many bizarre aspects, and is of very serious import for the eyes. An increasing number of cases are being reported and with them the clinical features are becoming more clear.



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The disease is characterized primarily by bilateral uveitis associated with retinal detachment. The distinction between Harada's disease and Vogt-Koyanagi syndrome depends on the location of the inflammation. In Harada's disease, which has a somewhat better prognosis, the inflammation is limited to the posterior segment. In Vogt-Koyanagi syndrome, it extends to the ciliary body and iris and usually results in complete loss of vision. Both of these entities are associated with one or all of the following conditions appearing at varying periods after the onset of the disease: headache, meningismus, deafness, dizziness, alopecia, vitiligo and poliosis. The eponymic designations of this condition are the result of reports of cases by Vogt[1], Harada[2] and Koyanagi[3]. There are excellent reviews of the literature by Parker[4], Carrasquillo[5], and Rosen[6], the latter having compiled 47 cases in 1945.

### Etiology

The causative factors in this disease are not known. Certain points stand out. It occurs in moderately pigmented individuals, most of whom have been of Japanese or Italian extraction. There are no reports of its occurrence in a blond individual, although in some reports the complexion is not mentioned. However, there is, as far as I can determine, only one case reported in the Negro race. According to Rosen[6], there is no sex differentiation; the age distribution varies from 10 to 52 years; and there is no evidence that the disease is related to tuberculosis or syphilis. Two instances of its occurrence in siblings are reported, the first by Salus[7], in two sisters who developed the condition within two months of each other; and the second by Benedict and Benedict[8], in a brother who contracted it two months after his younger sister. Harley and Wedding[9] reported finding actinomyosis in smears and on animal inoculation of aqueous humor and spinal fluid in their case. This has not been investigated in subsequent cases. As in all other diseases of unknown etiology, many theories have been postulated but none proven.

### Symptoms

The presenting symptom which brings the patient to the physician is loss of vision. This is rapid, progressive, and usually complete in the course of a week or two. It is frequently associated with headache, which may be severe. Dizziness and deafness appear later, about the second or third week. Alopecia, poliosis and vitiligo are later developments. Rosen[6] gives the following incidence of the symptoms: poliosis, 90%, alopecia 75%, vitiligo 63%, deafness 54%, headache 45%, dizziness 15%, lethargy 5%.

### Physical Findings

The eye involvement consists primarily of an optic neuritis and uveitis which begins in the posterior segment. There are cells in the vitreous and the aqueous. The retina loses its red color and becomes pale and elevated because exudate forms under it. The detachment may be quite marked. All vision, including light perception, may be lost. A varying amount of inflammatory change in the ciliary vessels may be noted, but the eyes are seldom violently inflamed. Iritis, with adhesions of the pupillary border to the lens, and capsular cataract, are common. In the later stages, the cataractous changes may involve the whole of the lens. Secondary glaucoma occurs with considerable frequency.

### Diagnosis

In the early stages, when the inflammatory process is confined to the posterior pole of the eye, the condition may be confused with optic

Read before the Sixty-Third Annual Meeting of the Hawaii Territorial Medical Association, Wailuku, Maui, May 1, 1953.

[1] Vogt, A.: Klin. Monatsbl. F. Angenh. 44:242, 1906.
[2] Harada: Nipp. Gank. Zass. 30:356, 1926.
[3] Koyanagi, Y.: Klin. Monatsbl. F. Angenh. 82:194, 1929.
[4] Parker, W. R.: Severe Uveitis with Associated Poliosis, Vitiligo and Deafness, Arch. Ophth. 23:439 (Sept.) 1940.
[5] Carrasquillo, H. F.: Uveitis with Poliosis, Vitiligo, Alopecia and Dysacousia (Vogt-Koyanagi Syndrome), Arch. Ophth. 28:385 (Sept.) 1942.
[6] Rosen, E.: Uveitis with Poliosis, Vitiligo, Alopecia and Dysacousia, Arch. Ophth. 33:281 (April) 1945.
[7] Salus, H.: Harada'sche Krankheit-Klin. Monatsbl. Augenh. 89:84, 1930.
[8] Benedict, W. H. & Benedict, W. L.: Uveitis, Poliosis and Alopecia in Siblings, Arch. Ophth. 46:510 (Nov.) 1951.
[9] Harley, R. D. & Wedding, E. S.: Syndrome of Uveitis, Meningo Encephalitis, Alopecia & Dysacousia, Am. J. Ophth. 29:526 (May) 1946.

neuritis. With the development of retinal detachment the diagnosis should be evident. The presence of a bilateral uveitis requires the consideration of sympathetic ophthalmia in the differential diagnosis and there are many points of similarity in the two diseases, but the absence of a history of perforating injury seems to properly classify the condition under discussion.

### Prognosis

The prognosis is always grave. Rosen[6] in his review found only 7 out of 47 cases regained vision of 20/50 or better in one eye. Two had better vision than this in both eyes. His review is on the Vogt-Koyanagi syndrome, which is supposed to carry a more severe prognosis. Parker[4], without designating either name but classifying his cases under the title of severe uveitis with the associated manifestations, states that 9 of 29 cases recovered vision of 20/50 or better.

### Treatment

There is up to the present time no accepted method of treatment that has any known value. Foreign protein, tuberculin, diphtheria antitoxin, and uveal pigment injections, as well as a host of drugs, have been used to no avail. There is no report of the use of cortisone up to the present writing except that of Benedict and Benedict[8], in whose two cases it was used at the time of ocular surgery seven years after the acute phase of the disease and presumably had no particular relationship to the active process. A poor result was obtained in one case, a good one in the other.

### Case Reports

Case 1: S. H., a Japanese man, age 48, was seen on April 16, 1943 with failing vision in the right eye of one week's duration. The vision was 20/400 in the right and 20/25 in the left eye. Ophthalmoscopic examination showed swelling of the nerve head with loss of the foveal light reflex and a faint dark discoloration of the central macular region of the right eye. In the left only loss of the foveal reflex was noted. On examination with the slit lamp and microscope a number of cells were noted in the aqueous and a few fine greasy deposits on the back of the cornea. He was found to have right purulent pan sinusitis and left ethmoidal sinusitis.

He was admitted to Hilo Memorial Hospital and the spinal fluid was examined with entirely negative findings. Right transantral and left intranasal ethmoidectomy was carried out. He was discharged to the care of his plantation physician.

He was next seen on May 24, 1943. At this time he complained of deafness and there was poliosis of the eyebrows, particularly on the left side. There was no perception of light in either eye. On examination with the slit lamp and corneal microscope, the right eye showed many deposits on the back of the cornea and many cells in the aqueous and on the anterior lens capsule. There were adhesions of the iris to the lens and the pupil could not be dilated well. However, areas of retinal detachment could be seen in the equatorial region above and below the disc. The condition in the left eye was similar, with less severe adhesions, but the retina was not visualized because of vitreous opacities. On September 8, there was light perception only in the lower nasal field of each eye. Dense posterior synechiae were present and a membrane was found across the pupil of each eye.

In May, 1946, he was re-admitted to Hilo Memorial Hospital by another ophthalmologist. The vision was noted as light perception in each eye. A cataract extraction was carried out on the right eye. On discharge ten days later a secondary membrane was forming across the pupil. In July, 1946, the same ophthalmologist removed the secondary membrane but there was no improvement in the vision.

Case 2: M. M., a Filipino man, single, age 37, was seen on April 15, 1952. He complained of loss of vision which began two weeks before and had progressed to the point where he was practically blind. On the day after the onset he noticed frontal headaches. Three days prior to the first examination he noticed tinnitus and deafness. The vision failed more rapidly in the left eye. The past and family histories were noncontributory.

On physical examination, he was able to count fingers at 2 feet in the right and 1 foot in the left eye. He could recognize hand motions in all fields in each eye. The pupils were 2 mm. in diameter and did not react to light. There was moderate ciliary injection in each eye. The extraocular functions were apparently intact. When the pupils were dilated with atropine, there was an adhesion of the pupillary border of the iris to the lens capsule on the nasal side in each eye, which eventually separated. Slit lamp examination showed many deposits on the back of each cornea and many cells in the aqueous and vitreous. On ophthalmoscopy, extensive detachment of the retina was noted in each eye; neither nerve head could be seen, but when the vessels came out of the funnel caused by the detachment, there was obvious exudate and a few scattered hemorrhages. The elevation of the retina was greatest in the lower temporal quadrant of each eye where it was best seen with a plus 12 lens. Where the vessels emerged the elevation was plus 6 diopters.

General physical examination revealed purulent infection of the right maxillary sinus from which a culture was taken. An audiogram showed a general depression of all tones averaging about 40 decibels, most marked in the higher frequencies in both ears. The left ear was slightly worse than the right. There were no other significant physical findings.

The patient was admitted to the hospital. Admission X-ray of the chest was negative. The white blood count was moderately elevated with an increase in the polymorphonuclear cells. Spinal fluid examination revealed a pressure of 138 mm., 165 cells consisting of 8 polymorphonuclear and 157 lymphocytes, protein 34 mgm. %, sugar 109 mgm. %, chlorides 686 mgm. %, and no globulin. The mastic test was normal. A smear was negative on acid fast and gram stains. The culture was negative for acid fast bacilli at the end of six weeks. The Eagle was negative on the blood and a Wassermann on the spinal fluid was also normal. Antrum irrigation four days after admission did not produce any exudate. A culture of the original antrum washings produced a few alpha hemolytic streptococci.

Four days after admission a second spinal puncture was done. There were 7 polymorphonuclear neutrophiles and 100 lymphocytes present. Some of this fluid was injected into the anterior chamber of a rabbit. There was

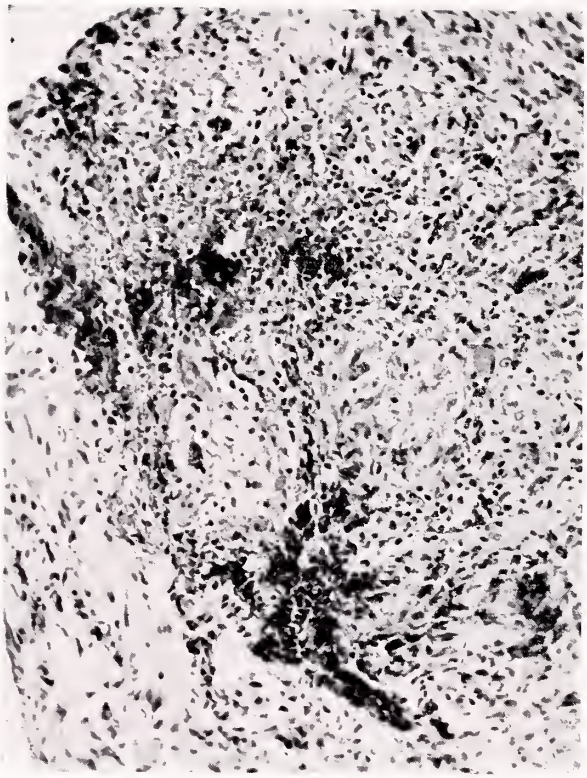


Fig. 1. Focal granulomatous lesions in iris composed of histiocytic cells. x265.

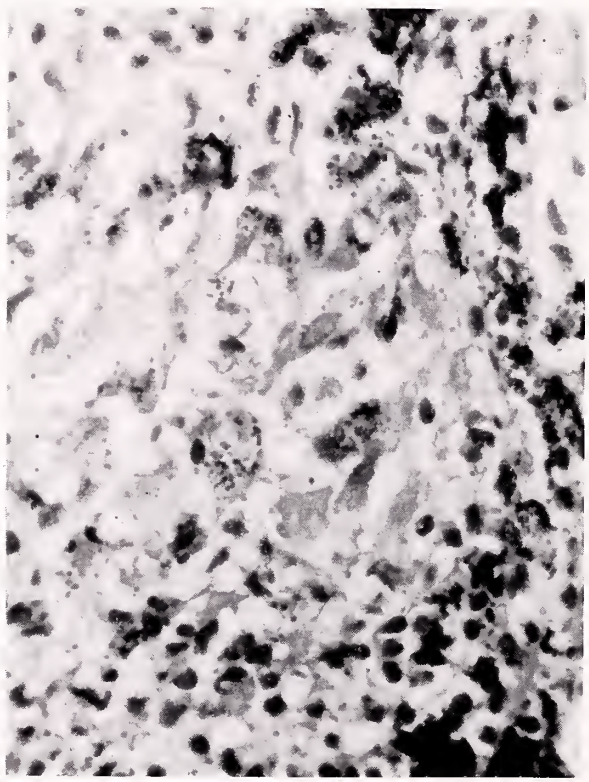


Fig. 2. Granuloma, iris. x800.

no reaction at the end of three weeks. Unfortunately, this was an albino rabbit.

The patient was given cortisone, 100 mgm. daily, and cortisone drops were used in the eyes every three hours. At the end of a week he appeared improved, subjectively, and was sent back to the plantation hospital, where cortisone was continued. At the time of discharge his hair had begun to fall out and he later became almost completely bald.

On July 17 the vision had improved to 20/70 in each eye. The hearing was normal. There was a marked alopecia of the scalp and outer portion of the eyebrows. The remaining hair in the head was white. There were scattered areas of vitiligo on the vertex. Ophthalmoscopic examination showed the retina entirely reattached. There were vitreous opacities present.

In September he was again examined. The vision in the right eye could be corrected to 20/25. However, the left vision had failed to 20/300 and the tension in the left eye had risen to 100 McLean. There was iris bombé in the left eye. He was hospitalized and a transfixation of the lower part of the iris of the left eye was carried out. This reduced the tension to 29 McLean, where it remained for over a month.

The patient missed his November appointment and when seen on December 11, there was a marked change. He had not used ophthalmic cortisone for six weeks. The vision was limited to light perception. The iris was markedly thickened in both eyes and there was a pupillary membrane in each eye. There were cataractous changes in the left lens. The tension in the right eye was normal; in the left it was again elevated to 60 McLean.

He was again admitted to Hilo Memorial Hospital and left cataract extraction carried out. Full iridectomy was done above. The iris was very thick and friable and had to be removed in several pieces to obtain a full coloboma. During the pre-operative and post-operative period he was given cortisone parenterally as well as locally in the eye. Recovery was uneventful. There were many vitreous opacities present at the time of cataract extraction. When last seen on February 12, 1953, there was a secondary membrane across the left pupil and vision was limited to light perception in the left eye. In the right he recognized hand motions at 18 inches.

## Pathological Report

Gross examination: Present were three fragments of black tissue that measured from less than 1 mm. to 2 mm. in diameter.

Microscopic examination of these tissue fragments revealed the presence of focal collections of plump histiocytes, fibroblasts, collagen fibers and lymphocytes. These areas were oval in outline. Some of the histiocytes contained pigment which could be identified as melanin. Separating these small foci from one another was a dense collagenous connective tissue containing a large number of pigment-bearing histiocytes. The histiocytic foci noted resembled the granulomatous iritis seen in sympathetic ophthalmia. The tissue slides were shown to Dr. J. Arnold deVeer, Pathologist, Brooklyn, New York, Eye and Ear Hospital. He noted the similarity of the lesion to that seen in sympathetic ophthalmia and raised the question of sensitivity to uveal pigment, in view of the large amount of phlogocytic pigment present.

## Discussion

This case is presented for several reasons. First, there are very few reports of tissue examination in this disease. Second, there are no reports up to

the present time of the use of cortisone in the treatment of this syndrome. In this case it appeared that the preparation was of great value in the early stages, since improvement was rapid and spectacular. However, after a recrudescence of the disease it did not appear to have any particular effect. It would appear that its use should be continued for a long period to achieve a cure. Cortisone has a very beneficial effect in sympathetic ophthalmia, and since there are many points of similarity between it and the condition under discussion it would appear that cortisone should be of value.

Finally, it should be pointed out that this is a disease affecting the pigment or melanin bearing tissues. There is melanin in the uveal tract in very great concentration, and the disease is most intense in the eyes and always bilateral. There is melanin in the skin in varying amounts, depending on the complexion of the individual and there is melanin in the hair. This accounts for the vitiligo and poliosis and presumably the disturbance of the pigment in the germinal layer of the hair follicle accounts for the loss of hair.

There is some controversy regarding the presence of pigment in the internal ear. Cunningham[10] states that there are pigment granules in the cells of Hansen in the organ of Corti, and a disturbance of this melanin could explain the deafness. He also describes pigment granules in the hair cells of the utricle, saccule and the ampullae of the semicircular canals, and involvement of this pigment can account for the dizziness that sometimes occurs.

Melanoblasts are found in the pia mater of the ventral surface of the medulla oblongata, according to Maximow and Bloom[11]. The presence of meningismus with an increased cell count in the spinal fluid could be the result of involvement of this tissue.

It appears that in Harada's disease and the Vogt-Koyanagi syndrome we are dealing with a diffuse condition involving melanin bearing tissues. This condition is an inflammatory one, whether it be on an allergic or infectious basis. The present terminology is confusing and it is suggested that the disease be called diffuse melanitis.

## Summary

Two cases falling in the classification of Vogt-Koyanagi syndrome are reported. In the second case tissue from the iris was examined microscopically and revealed changes closely resembling sympathetic ophthalmia. In this case cortisone used locally and parenterally produced marked improvement but recurrence of the inflammation took place when it was discontinued. It is suggested that the disease be called diffuse melanitis.

## Acknowledgment

Acknowledgment is gratefully made to Dr. Grant N. Stemmermann for his assistance in the pathological report and to Dr. I. L. Tilden for the photomicrographs.

## Discussion

DR. THOMAS W. COWAN: I believe that Dr. Crawford has just about said all that can be said concerning this syndrome: that the difference between Harada's disease and the Vogt-Koyanagi syndrome appears to be that of intensity of involvement rather than a difference in the pathological picture. If the disease is limited to the posterior quadrants and the detachment is ultimately spontaneously replaced, then it is classified as Harada's. If the disease process is more uniform in the uveal tract and the detachment does not return spontaneously, it is Vogt-Koyanagi. The complications and accompanying clinical findings are about the same in both instances.

I wish to emphasize Dr. Crawford's statement that this is a rare entity, because up to 1951, only about 50 cases of Vogt-Koyanagi are reported and only about 10 of Harada's. This syndrome is usually bilateral, although Dr. Hogan in San Francisco presented a unilateral case in a 52 year old individual.

Surgery in these cases must always be done cautiously and with the knowledge that the prognosis is bad, whether surgery be done for the secondary glaucoma or the complicated cataract. I believe that ophthalmic surgeons should do surgery only as a last resort and then with the full realization that in spite of accepted technique, the end result may not be gratifying. It is unfortunate that a good clinical trial of cortisone was not possible, for we might have found another good use for this steroid.

Because of the meningeal complications and the bilateral extent of the disease, the name uveo-encephalitis has been suggested by Dr. Cowper, of Boston. This name seems, to me, to be somewhat more descriptive than the newly coined term of Dr. Crawford's.

Both of these diseases, pathologically, produce a chronic granulomatous uveitis, invariably bilateral, and closely associated, pathologically, with sympathetic ophthalmia. I would like to spend a moment or two in comparing, pathologically, a proven case of Vogt-Koyanagi and a proven case of sympathetic ophthalmia. I will show a normal section first for your orientation. [Slides shown: No. 1, normal iris section; No. 2, infiltrated choroid of a Vogt-Koyanagi; No. 3, nodular iris in a Vogt-Koyanagi; No. 4, sympathetic nodule in an iris.]

I wish to thank our Pathological Department and particularly Dr. Tilden for the preparation of these slides and Dr. Crawford for the privilege of discussing his very excellent paper.

[10] Cunningham: Textbook of Anatomy 31:520 (June) 1944.
[11] Maximow, A. A. & Bloom, W. A.: Textbook of Histology, W. B. Saunders Co., 4:61, 1943.

# EDUCATION IN PARENTHOOD

ALICE KOHLER, R.N., and MABEL L. DAVIS, R.N.
HONOLULU

DR. JOHN WILLIAM BALLANTYNE (1861-1923) is credited with being the first to establish a clinic for expectant mothers.[1] In his studies of the newborn, he became aware of the importance and value of routine prenatal care in obstetrics. Prenatal classes followed as a natural outgrowth of his observations of the needs of these parents. Since that time, classes for expectant mothers, and later classes for expectant fathers, have been promoted in many progressive communities.



MRS. KOHLER

Classes have frequently been sponsored by large hospital clinics, health agencies such as the American Red Cross, and local health departments. More recently, private physicians specializing in obstetrics and in pediatrics have conducted similar programs for their own patients. Adult education projects have included classes in parent education. The importance of family life and family living is being recognized as a vital part of any parent education program today.

In the Territory of Hawaii, well-organized group projects reached about 13% of all expectant mothers in 1952, most being in the City of Honolulu. Mother and Baby Care classes are being conducted in rural and city health centers, in several hospital out-patient departments and in two private medical practices.

At the beginning, most of this teaching reached the group whose financial status permitted attendance at free or public clinics. The picture has changed very much—more prospective parents, regardless of economic status or educational background now avail themselves of this specialized instruction. As an example, a recent class membership listed the following occupations: 6 clerk-typists; 2 saleswomen; 1 cashier; 1 nutritionist; 1 nurse; 1 hairdresser; 1 dressmaker; 1 telephone operator; 1 high school teacher; and 4 housewives. We've had social workers, psychologists, librarians and wives of professional men.

Figures on the three major teaching groups are as follows:

| | CLASSES | ATTENDANCE | AVERAGE IN CLASS |
|---|---|---|---|
| Private physicians classes..... | 23 | 481 (day & night) | 22 |
| Dept. of Health Nurses..... | 44 | 449 | 11 |
| American Red Cross..... | 53 | 1070 (day & night) | 20 |
| | 120 | 2000 | |

The Department of Health nurses taught on Department of Health time, while many of these nurses, and other qualified instructors, taught Red Cross classes on off-duty time. The trend in the city is toward more evening classes for both expectant mothers and fathers.

What do we hope to accomplish in these classes? According to *Briefs* (a quarterly publication from the Maternity Center in New York), "The chief aims of parents' classes are (1) to relate the coming of a baby to all of living and not just the nine months of pregnancy and the three months following the birth of the baby; (2) to develop a sense of security during the months of pregnancy and a feeling of accomplishment during labor and a readiness to nurse and care for the baby with real enjoyment."[2]

To achieve these objectives, certain scientific facts regarding anatomy and physiology are taught, which help parents understand what is happening during pregnancy, labor and delivery. The growth and development of the baby month by month is told as the story of reproduction is reviewed; the importance of prenatal hygiene is stressed as we describe the changes that occur within the mother's body; the basic principles of nutrition are discussed in relation to the various stages of the baby's development and the importance of maintaining a good nutritional state in the mother throughout pregnancy; labor is emphasized as a natural physiologic process and the mother is given an understanding of how a baby is born; good post-partum and newborn care is explained as they pertain to the physical and emotional changes that occur during the puerperium and to the baby's development and needs immediately after birth.

The major objective in any obstetrical program is a physically and emotionally well mother with a happy, healthy baby. The mother who has attended classes is better prepared both psychologically and materially for the process of labor, de-

Read before the Sixty-Third Annual Meeting of the Hawaii Territorial Medical Association, Wailuku, Maui, May 1, 1953.

[1] Thompson, Lloyd J., and Barber, Marian: Mothers' Classes for Physical and Emotional Health, Pub. Health Nursing, 41:427 (Aug.) 1949.

[2] Peck, Elizabeth: Mothers' Classes Answer a Community Need, Pub. Health Nursing, 43:616 (Nov.) 1951.

livery and parenthood than is the mother who has not had any instruction. Group discussions complement the supervision given by the physician. Mothers go through pregnancy more at ease as they learn to express their fears and anxieties and discuss them in the permissive atmosphere of the class. Superstitions and misconceptions frequently disappear with better understanding. Parents are more confident and less afraid because they understand what happens during labor and delivery and are able to cooperate and relax more readily.

One of the major assets of a parent's class is the opportunity to ask questions. The meetings are usually conducted in an informal manner and questions are encouraged. Time for individual counselling and guidance follows each class.

Parents having their first babies are especially enthusiastic. They are receptive to new ideas and constructive instruction. They quickly show increased confidence and self-reliance. The understanding and insights gained help them maintain a cheerful philosophy and happy acceptance of pregnancy. Education is most successful when the student is in a state of readiness. Expecting a baby, especially a first baby, is a period when there is a great eagerness to learn. Most mothers attending class are primigravidas. The multipara is always welcomed, but often she cannot attend regularly because of home responsibilities. However, she needs the encouragement and guidance just as much as the primigravida. Often she is faced with more problems and an entirely different situation than in her previous pregnancies.

The instructor should be a friendly, emotionally mature person, keenly interested, with a sympathetic understanding of the feelings of the expectant parents.[3] Equally important is an awareness of her own behavior and role in each situation. She must understand the principles of obstetrics and good maternity nursing and must keep abreast of current developments. In addition to her basic nurse's training, she should have a knowledge of teaching methods and their application. A public health nursing background is a definite asset as it gives her knowledge of the home and community resources available.[4] The good teacher loves to teach. She sees the significance of helping to lay foundations for parent-child relationships that will have positive far reaching effects.

With the present interest in natural childbirth, relaxation exercises and rooming-in, there has been a fundamental change in our educational focus in this area. In the past, our primary concern has been in promoting and maintaining physical health, little attention being given to mental and emotional health and the role that they play in the maternity cycle and early period of infancy. Emotional factors and their relationship to good prenatal care is a fairly new approach in mother's classes.

The expectant father is having a greater share in promoting safe and satisfying maternity experience and adequate child care. There is a growing awareness of the importance of parent teamwork for sound family living. The traditional picture of the nervous, chain-smoking father in the maternity waiting room is outmoded—he was the "forgotten man" who paid the bills. The expectant father who understands what is taking place and cooperates throughout the period of pregnancy can have a profound effect on the expectant mother's physical health and emotional outlook. His own fears and apprehensions, which are many, will disappear as he understands the successive events of pregnancy and labor. The expectant father identifies himself in the parent role when he attends classes with his wife. The trend toward more classes for both parents is significant in view of the modern concept of family living. Most evening classes are for the combined group of fathers and mothers, while day classes are attended mainly by the expectant mother.

Parenthood is the greatest of all vocations. Dr. Brock Chisholm, Director General of the World Health Organization, once stated, "The biggest business in the world and the most important business in the world and the business that overweighs all other values in the world is the business of raising children."[5] Preparation for family living and understanding positive health practices is necessary in this present complex world. Just as the athlete trains for the marathon, so parents need to train for the challenging experience of bringing a child into the world. The average boy or girl receives a superficial background in biology and personal hygiene with scarcely any orientation in terms of family relationships. The home and the school need to be strengthened to help prepare young people for home making and parenthood, and to develop wholesome attitudes toward family living and sound basic philosophies. Physicians and nurses who recognize and accept their share of the responsibility of teaching, contribute vastly to the emotional health and well-being of their families. By working together to fulfill this need, we will promote a better informed, better adjusted group of mothers and fathers to guide the leaders of tomorrow.

[3] Chisholm, Rita: Parents Class: A Fertile Field for Mental Health Concepts, Pub. Health Nursing, 41:273 (May) 1952.

[4] Maternity Center Association: Public Health Nursing in Obstetrics, Part IV, New York, 1948.

[5] Thoms, Herbert, and Roth, L. G.: Understanding Natural Childbirth, New York, McGraw-Hill, 1950.



# *The President's Page*

## THE AMERICAN WAY

It was a clear bright day as I stood on the top deck of the Empire State building to view the immensity of Manhattan. High above the forest of skyscrapers I thought I could feel the awesome swaying of this majestic tower. It reminded me of a moment in my boyhood when I had ascended the tallest coconut tree in Waikiki. The gentle swaying of the tree gave me that same sensation, and I wanted to hold on tightly. As I gave the rail a tight squeeze the man next to me seemed to sense my plight and he said, "I had that feeling on my first trip up. I have been here several times since and I always enjoy the sight of New York from here." "It is a beautiful picture, isn't it?" I replied, and I felt much better and more secure by then.

He spoke with an accent that seemed to identify him as European . . . "but I'm a naturalized American citizen now and a 'new' New Yorker too!" I told him I was from Hawaii and we became quite friendly, Gus and I. As we watched the steady streams of cars and people on the avenues far below we talked of many things. I asked Gus what impressed him most in America and without hesitation he said, "Freedom."

"In America we are free to choose the place in which we want to live. We are free to choose the people for whom we wish to work. We have a free choice of the churches in which to worship, a free choice of the markets in which to purchase our food and a free choice of the clothes we wish to wear. We have a free choice of the cars and appliances we wish to purchase. We have freedom of choice in expressing our own opinion and not what someone in a uniform tells us to say. We are free to choose those whom we wish to have represent us in public office. We are free to choose the kind of services we wish to purchase. And we can choose our own physician to care for our most treasured possession, our body." Gus was impressed by the things that we take for granted.

We rode the express elevators to the street level in silent thought. I was thinking: "Yes, freedom of choice is the stimulus that creates an incentive in the individual merchant and in the physician to improve the quality of his product and the quality of his services. We should always have a freedom of choice and especially a free choice of physician. That is the American Way." When we parted he disappeared quickly in the steady stream of people on the Avenue of the Americas.

R. K. Chungstroom M.D.

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## [EDITORIALS]

### GOODBYE, SISTER JOLENTA—AND GODSPEED!*

In 1926 when the Community of the Order of Saint Francis at Syracuse opened St. Francis Hospital in Honolulu, there were many doubts, particularly among the medical fraternity, that there was need of a new hospital and that it could succeed. Mother Flaviana and her staff struggled against almost insurmountable odds to keep the fifty-bed hospital open. For thirteen years it was "touch and go," and there were few of us who fully appreciated that we had been given one of those all too rare opportunities to help in the growth and development of what was to become one of the outstanding hospitals in Hawaii. To some of us, in spite of physical limitations, it offered a haven for our more sensitive patients and we prayed that the financial burden would not force the Sisters to abandon their work here.

In 1933 a young, quiet but firm Sister came as Director of Nurses. In her two years in this position the standard of nursing—the efficiency on the floors—showed marked improvement and we felt a definite sense of loss when Sister Jolenta was placed in charge of the hospital at Kalaupapa. Fortunately our loss was but temporary, for in 1939, with the problems of defense preparation stretching our every facility, with St. Francis trying to care for sixty-five or seventy patients in fifty beds, with (as many of you will remember) patients even in the corridors and in the basements —Sister Jolenta returned.

The accomplishments of the following fourteen years mark a page in the hospital history of Hawaii. Few women—indeed few men or women—have ever demonstrated greater executive ability than our Sister Jolenta, surrounding herself with able advisors, planning patiently and well, firm but always fair and just, meeting each emergency with courage and quiet determination. Under her guidance, through the trying years of the war the hospital grew, met the challenge of tremendous demands — and emerged the beautiful hospital home which we have today.

Now God in His wisdom, working through the Third Order of the Sisters of Saint Francis of Syracuse, has ordained that Sister Jolenta shall assume the duties of Superior General. She is the first nurse to be so elected. In this honor you and I glory, sharing with the Sisters of the Order the confidence that in her work as the Reverend Mother Jolenta she will carry on with the same loving heart and the same great purpose which we have known so well.

To Mother Jolenta we wish to reaffirm our love and affection, knowing that though she will not be with us here in body, our Sister Jolenta will always be with us, extending her thoughts and her works across the many miles. We of the medical profession send her our Aloha—Aloha with all this wonderful word connotes.

PAUL WITHINGTON, M.D.

*Excerpt from a tribute to Mother Jolenta written by Dr. Withington for the Medical Staff of St. Francis Hospital and read at their meeting, Friday, August 16, 1953.

## TUBERCULOSIS IN HAWAII, 1952
### Leahi Hospital Report

A drop in Hawaii's tuberculosis mortality rate from 57.2 to 14.7 per hundred thousand persons per year has occurred in the past eight years. Instead of being worse off than all but 5 states in this regard, we are now better off than all but 12. And while our rate was dropping to one-fourth of its previous level, that of the United States as a whole dropped but one-half!

The total of known cases of tuberculosis in the Territory has increased from 1500 to over 5,000 during this period—largely as a result of more vigorous case-finding programs and changed methods of reporting. The proportion of these which are active, however, has dropped from nearly two-thirds to just over one-fourth, or about 1300 cases.

Of these 1300 cases, the proportion being cared for in sanatoria has risen from about one-half in 1945 to almost three-fourths in 1951. In that year, only 7 of Honolulu's 44 tuberculosis deaths occurred outside Leahi.

The percent mortality for far advanced cases—which had risen from 58 to nearly 60 from 1936 to 1946—has dropped in the past six years to 35; that for moderately advanced cases has dropped from 14 in 1936 to 3.9 in 1952.

As Dr. Perlstein points out in Leahi Hospital's annual report, this sharply declining mortality means that more active cases remain alive to require hospitalization and treatment. It increases the need for tuberculosis beds. It does not indicate that the tuberculosis problem has been solved.

Hawaii can be proud, however, of her progress in its solution. All the 48 states—and Hawaii—experienced a drop in their tuberculosis mortality between 1943 and 1951. Only 21 states, however—and Hawaii—improved their standing in this regard relative to the other states; and Hawaii's improvement was greater by a wide margin than that of any state.

## AMA POST-CONVENTION TOUR IN 1954

Talk up the forthcoming AMA Post-Convention Tour scheduled for next summer! It isn't too soon to start your friends planning on it.

The AMA meets in San Francisco June 21 to 25, 1954, and the tour to Hawaii afterward should be made by flying down and returning either by air or on the Lurline on July 3. Both Pan-American and United are making special arrangements to accommodate physicians who wish to make the tour.

Mention it to your friends; build it up; let's make it a well-attended affair and a real occasion!

## "HAWAII MEDICAL ASSOCIATION"

Hawaii's doctors won't be caught napping when—and IF—the Congress of the United States decides to string along with the framers of the Declaration of Independence and put an end to taxation without representation here by making Hawaii the forty-ninth State. The word "Territorial" was deleted from our territorial organization's name by the House of Delegates at our last annual meeting.

A change back to the original name of the "Hawaiian Medical Society" had been urged, but the delegates decided to change the name to "Hawaii Medical Association" instead.

We predict that this action by our House of Delegates will wind up by breaking all previous records for forehandedness, by a margin which will also break all previous records for margins.

Anyway, we're all set for the big change. Come on, Congress—let's go!

## THE AMERICAN MEDICAL EDUCATION FOUNDATION

In 1952, 7,259 physicians from 48 states, the District of Columbia, Hawaii and Puerto Rico made a contribution to the American Medical Education Foundation. The total amount donated was $906,533.82. This represents over 3 times the amount of money, from nearly 3 times the number of contributors, donated in 1951.

Hawaii's doctors have nothing to be proud of in this record. They are not ungenerous—100 of them have made donations to their own medical schools—but they are not cooperating with the AMEF fund project; only 5 of them made a donation to it in 1952, and 5 so far in 1953.

We are a little ahead of Puerto Rico, from which only one donation came; we are exactly even with the District of Columbia, and one up on tiny Rhode Island. Aside from these, only South Carolina (with 8 donors), Mississippi (with 9) and Tennessee (with 10) are even close to us; in only 8 other states have less than 20 doctors donated to the Foundation.

Let the 100 doctors in Hawaii who have donated to their own schools, and presumably will do so again, take note: *A donation to your own school can be transmitted intact and in your own name by the American Medical Education Foundation* (whose expenses are all borne by the A.M.A.).

Only in this way can organized medicine point up publicly the willingness of physicians to support their own schools, and the unwillingness of physicians to see Federal subsidization and its concomitant threat of Federal control enter into the picture.

# THIS IS WHAT'S NEW!

An overdose of **digitalis** in patients with congestive failure may initiate **paroxysmal auricular tachycardia** with block. Forty mEq. of **potassium** I.V. and stopping digitalis will usually result in restoration of normal rhythm. (Lown, B., et al. *Am. Heart* 45:589 [Apr.] 1953).

Don E. Eyles, after trying various drugs in the treatment of **toxoplasmosis** in mice concludes: ". . . I should want to be treated, if I developed toxoplasmosis, with **sulfonamides** plus the maximum safe dose of **Daraprim.** (The *Am. J. of Trop. Med. and Hygiene* 2:429 [May] 1953). The fact that an author advocating a certain form of therapy would himself prefer that therapy should he develop the appropriate disease is usually taken for granted. However, it is a bit more convincing when a surgical author concludes: "If I ever develop such an oma I would insist upon nothing less than a total ectomy, with removal of all adjacent structures of course." A medical therapist might be equally insistent that he would treat his own itis by removing from his diet all things that taste and take the prescribed medication at frequent enough intervals to remind himself always that he is sick.

Tomaszeweski used on six patients a little of the dog that might have bitten them to treat their hairy tongues. **Idiopathic black hairy tongue** treated with **aureomycin** and **penicillin troches** for 1 to 3 weeks does just fine. The hairy coat could be readily scraped off after treatment. (*British Med. J.* 4822:1249 [June] 1953).

Plummer and Hinkle have further studied the **illness** and **absence** from work history of **women in industry.** They find the high absence group characterized by almost all the ills that flesh and mind are heir to. These patients keep their private doctors filling out 20 times as many medical forms over 20 odd years as a patient in the low absence group. As this high absence group gets older they begin to lose various organs at an alarming rate (8 times as many appendectomies as in the low absence group as well as much higher removal of tonsils, ovaries, uteri, etc.). They were also more likely to have spines fused; industrial as well as other accidents and consequently long periods of being off work. What to do about all of this? Recognize; evaluate; and manage. (*Ann. Int. Med.* 39:103 [July] 1953).

**Androgens** (Testosterone propionate and methyl testosterone) are considerably **inferior** to estrogens in the treatment of **menopausal women.** Walker found 32% developed masculinizing symptoms and had a beard to contend with, along with their hot flashes. Only 27% were relieved of their menopause symptoms—less than in control groups. (*Am. J. Obst. & Gynec.* 66:375 [Aug.] 1953).

Kirschner and Garlock of Mt. Sinai, N.Y. urge **subtotal gastrectomy** as the procedure of choice for malignant lesions of the distal portion of the stomach. Reason—total gastrectomy gives no higher 5 year survival rate but the vast majority of those that do survive "become emaciated digestive cripples, difficult to manage therapeutically." Their operative mortality with the subtotal procedure 13.6%—5 year survival 23.3% (Includes Hodgkin's and lymphosarcoma). (*Ann. Surg.* 138:1 [July] 1953.)

Also in N.Y., Raffl and Kelley studied 228 consecutive cases of **Ca** of the **stomach** with 76% being operated upon. Their figures: 5 year survival rate **6.6%**; operative mortality 14%. They do not rationalize the low cure rate by pointing out the symptomatic improvement after palliative surgery but state flatly that palliative surgery offered very little palliation and was accompanied by a high mortality. "In our hands, at least, the results of **subtotal resections** for carcinoma of the stomach have been very **discouraging.**" (*Cancer* 6:756 [July] 1953).

Cloward discusses the pros and cons of **spinal fusion** in the treatment of **ruptured intervertebral discs.** He believes that all patients with proven ruptured intervertebral discs should have a vertebral body spinal fusion. (*Am. J. Surg.* 86: 145 [Aug.] 1953).

**Iproniazid** has been used in the treatment of **bone** and **joint tuberculosis** by Bosworth and coworkers. Sixty-six patients were treated—most of whom had streptomycin or Isoniazid with mediocre or poor results before starting Iproniazid. Twenty-nine cases "healed." They believe that Iproniazid is the drug of choice in the treatment of bone and joint tuberculosis. (*J. Bone and Joint Surg.* 35A-577 [July] 1953).

FRED I. GILBERT, JR., M.D.

# HMSA—Its Place in the Community

## True Values of a Service Plan

J. R. VELTMANN, *General Manager*

The title "THE SERVICE PLAN FOR HAWAII" in the field of Prepaid Medical protection is highly valued by HMSA. Service features of the plan are very important to members—yet its real advantages are frequently overlooked by prospective members who are offered "Indemnity Dollars" coverage. It has been proven that in times of real need, the Service Plan is most effective.

Our most outstanding service feature is doctor support. Doctors in the community, through their Medical Society, sponsor HMSA and render "Service" benefits to members with individual annual income of less than $3,600.00 or whose family income is less than $4,800.00. This feature is often misconstrued as a limitation but we cite the following case as an example of its application:

*Case No. 22596* was involved in an accident and required the services of two surgeons who performed several surgical procedures. The bills for services rendered amounted to $1,450.00. On discovery that the patient was a member of HMSA who qualified within the income clause, the surgeons accepted the HMSA allowance as payment-in-full for their services. This generous and splendid cooperation by the surgeons saved the member hundreds of dollars and contributed to his peace of mind.

By their action, the doctors displayed their wholehearted support of HMSA. On the other hand, whenever unusual complications are reported, HMSA considers additional compensation above scheduled amounts which are developed through combined efforts of the members of the Medical Society and HMSA. The following case depicts this feature:

*Case No. 8838* suffered a ruptured appendix with resultant complications. On a report of the complications from the surgeon, HMSA increased the doctor's allowance for the procedure by $25.00. A week later, further complications developed which required more service. An additional $75.00 was allowed the doctor for this service, thereby HMSA paid $100.00 over its normal allowance for this procedure.

From the two examples cited, one can readily see that the close liaison between HMSA and its participating physicians results in a tremendous benefit for the members.

Hospital benefits on a service basis are another important feature. Room and board service is not limited to indemnity dollars, but the Association pays the existing ward rate, and such rate is as high as $11.00 per day in Honolulu. Many prospective members are attracted by offers which advertise "Up to $240.00 for hospital extras." Figuratively, this amount appears impressive, but when major surgery is involved, such an indemnity allowance becomes limited. The following is a good example of this feature:

*Case No. 43221* developed a condition which required major surgery. In addition to paying $285.00 for room and board service, HMSA paid a total of $509.35 for hospital extras which were in accordance with the member's certificate. Hospital extras for this particular case were more than twice the maximum allowance of $240.00 usually offered.

The entire HMSA program is designed to serve the member and his dependents when he needs help most. The following are illustrative cases where HMSA assistance played a big part in a time of need. A member is never cancelled as a beneficiary because of high claims usage; as a matter of fact, he is allowed to continue on an individual basis when he leaves an insured group.

*Case No. 14821* and his family have been members of the plan for four years. The first year, the family required little medical attention. The second year, HMSA allowed $178.50 in benefits, a total of $907.90 in the third year and the fourth year total was $616.40. In a three-year period, this family received $1,702.80 in benefits.

*Case No. 43221* and his wife joined the plan and within one year, the Association paid claims totaling $1,446.88.

*Case No. 23285* and his family joined the plan in 1949. In 1950, HMSA paid claims totaling $268.00; $291.00 in 1951 and $1,289.70 in 1952, for a total of $1,848.70 for the three-year period.

*Case No. 9708* and his family had been members of HMSA for several years before major illnesses struck the family. In 1949, HMSA paid claims totaling $613.20; $924.25 in 1950, $236.50 in 1952 and a total of $1,004.35 in the first few months of 1953. The total amount of benefits received by this family for this period totaled $2,778.30.

The above are only a few cases of what serious illness can mean to a family. Each month, HMSA pays for about twelve cases which range between $500.00 and $1,000.00 for doctor and hospital services, and there have been times when two members of the same family incurred such large bills within a short period.

Grateful members often write the plan and others express their appreciation in person. An example of an unsolicited expression is quoted below:

"I want to try to express our gratitude for the wonderful way in which this was done. As members we already had ample reason to rely on the Association for help in our family illnesses. But we had not thought in terms of anything of such large dimensions as this recent operation. As we figure it, something over $700.00 was paid out on our behalf to the two hospitals and three doctors involved. We are profoundly grateful to you and to all who have helped us meet this crisis. We are glad we entered the HMSA under the group plan."

HMSA is always ready to serve its members and, after review of cases with large unexpected medical bills, we wonder whether any person can afford to be without some form of medical protection. Every individual is eligible and can become an HMSA member through his place of employment. Others who meet enrollment requirements may become members through community enrollment.

# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*
MRS. FLORENCE GRAY, *Assistant Librarian*
Phone 65370
8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.
Monday through Friday
Closed Saturdays at noon and Sundays
Closed all day and evening on National holidays
and at noon on Territorial holidays

## Recent Acquisitions

**Allergy**

Coca, A. F. *Familial nonreagenic food allergy.* c1953. (gift of publisher).

Criep, L. H. *Essentials of allergy.* c1945. (gift of Dr. Li).

**Cancer**

Armed Forces Institute of Pathology. *Atlas of tumor pathology.* Sec. IV, Fasc. 14; Sec. IV, Fasc. 15; Sec. V, Fasc. 17; Sec. VIII, Fasc. 31b and 32; Sec. X, Fasc. 35 and 37. 1952-53. (gift of Armed Forces Institute of Pathology).

Cade, Sir Stanford. *Malignant disease and its treatment by radium.* 3 v. 2nd ed. 1948-1950.

Fried, B. M. *Bronchiogenic carcinoma.* c1948.

Gregory, J. E. *Pathogenesis of cancer and applied therapy.* c1952.

Hultborn, K. A. *Cancer of the colon and rectum.* 1952.

Ingalls, R. G. *Tumors of the orbit and allied pseudo tumors.* c1953. (gift of publisher).

Willis, R. A. *The spread of tumors in the human body.* 2nd ed. 1952.

**Chest**

Segal, M. S. *Chronic pulmonary emphysema.* c1953. (gift of publisher).

Thorek, Philip. *Diseases of the esophagus.* c1952. (gift of publisher).

**Dermatology**

Waldbott, G. L. *Contact dermatitis.* c1953. (gift of publisher).

**Diabetes**

Rifkin, Harold. *Diabetic glomerulosclerosis.* c1952. (gift of publisher).

**Diagnosis**

Dunphy, J. E. *Physical examination of the surgical patient.* c1953. (gift of publisher).

Todd, J. C. *Clinical diagnosis by laboratory methods.* 12th ed. c1953. (gift of publisher).

**Electrocardiography**

Riseman, J. E. F. *P-Q-R-S-T.* 3rd ed. c1952. (gift of publisher).

**Heart**

Gould, S. E., ed. *Pathology of the heart.* c1953. (gift of publisher).

**Hematology**

Albritton, E. C., ed. *Standard values in blood.* c1952. (gift of publisher).

**Immunology**

Pappenheimer, A. M., Jr. *The nature and significance of the antibody response.* c1953. (gift of publisher).

Raffel, Sidney. *Immunity, hypersensitivity, serology.* c1953. (gift of publisher).

**Infectious Diseases**

Anderson, H. H. *Amebiasis.* c1953. (gift of publisher).

Wilson, M. G. *Rheumatic fever.* c1940.

**Leprosy**

Arnold, H. L., Jr. *Modern concepts of leprosy.* c1953. (gift of publisher).

**Liver**

Berman, Charles. *Primary carcinoma of the liver.* 1951.

Hoffbauer, F. W., ed. *Liver injury. Trans . . . 11th conf., April 30-May 1, 1952.* c1953. (gift of Josiah Macy, Jr., Foundation).

Poppel, M. H. *The roentgen aspects of the papilla and ampulla of Vater.* c1953. (gift of publisher).

**Neurology and Psychiatry**

Despert, J. L. *Children of divorce.* c1953. (gift of publisher).

Ford, F. R. *Diseases of the nervous system in infancy, childhood and adolescence.* 3rd ed. c1952. (gift of publisher).

Grassi, J. R. *The Grassi block substitution test for measuring organic brain pathology.* c1953. (gift of publisher).

Hall, B. H. *Psychiatric aide education.* c1952. (gift of publisher).

Haymaker, Webb., ed. *The founders of neurology.* c1953. (gift of publisher).

Hoch, P. H., ed. *Current problems in psychiatric diagnosis.* c1953. (gift of publisher).

McDonald, J. J. *Correlative neuroanatomy and functional neurology.* 6th ed. c1952. (gift of publisher).

Patterson, C. H. *The Wechsler-Bellevue scales.* c1953. (gift of publisher).

Podolsky, Edward, ed. *Encyclopedia of aberrations.* c1953. (gift of publisher).

Strecker, E. A. *Practical clinical psychiatry.* 5th ed. c1940. (gift of Dr. Li).

Tarlov, T. M. *Sacral nerve-root cysts.* c1953. (gift of publisher).

Tarsy, J. M. *Pain syndromes and their treatment.* c1953. (gift of publisher).

Tasaki, Ichiji. *Nervous transmission.* c1953. (gift of publisher).

Van Brugghen, Adrien. *Neurosurgery in general practice.* c1952. (gift of publisher).

Wartenberg, Robert. *Diagnostic tests in neurology.* c1953. (gift of publisher).

Williams, H. L. *Meniere's disease.* c1952. (gift of publisher).

Wolff, H. G. *Stress and disease.* c1953. (gift of publisher).

**Nursing**

Bridgman, Margaret. *Collegiate education for nursing.* c1953. (from Nurses' Association).

Chayer, M. E. *School nursing.* c1937. (gift of Miss Otto).
Davis, D. M. *Urological nursing.* 5th ed. c1953. (from Nurses' Association).
Deming, Dorothy. *Careers for nurses.* 2nd ed. c1952. (from Nurses' Association).
Finer, Herman. *Administration and the nursing services.* c1952. (from Nurses' Association).
Hodgson, V. H. *Supervision in public health nursing.* c1939. (gift of Miss Otto).
Krause, M. V. *Nutrition and diet therapy.* c1952. (from Nurses' Association).
Manhattan Eye, Ear & Throat Hospital. *Nursing in diseases of the eye, ear, nose & throat.* 9th ed. c1953. (from Nurses' Association).
N.E.A. & A.M.A. *Health education.* c1941. (gift of Miss Otto).
Rattner, Herbert. *Dermatology: a textbook for nurses.* c1953. (from Nurses' Association).
St. Mary's Hospital. *Operating room technic.* 4th ed. c1952. (from Nurses' Association).
Seyffer, Charlotte, ed. *The organization of hospital nursing services.* c1952. (from Nurses' Association).
Solomon, Charles. *Pharmacology and therapeutics.* 6th ed. c1952. (gift of publisher).
Witton, C. J. *Laboratory manual for microbiology.* c1952. (from Nurses' Association).

**Ophthalmology**

Adler, F. H. *Gifford's textbook of ophthalmology.* 5th ed. c1953. (gift of publisher).
Bruetsch, W. L. *Syphilitic optic atrophy.* c1953. (gift of publisher).
Harrison, W. J. *Ocular therapeutics.* 2nd ed. c1953. (gift of publisher).

**Orthopedics**

Banks, S. W. *An atlas of surgical exposures of the extremities.* c1953. (gift of publisher).
Hauser, E. S. W. *Diseases of the foot.* 2nd ed. c1950. (gift of publisher).
Moseley, H. F. *Shoulder lesions.* c1945. (gift of Dr. Li).
Traut, E. F. *Rheumatic diseases.* c1952. (gift of publisher).

**Pediatrics**

Senn, M. J. E., ed. *Problems of infancy and childhood. Trans . . . 6th conf., March 17/18, 1952.* c1953. (gift of Josiah Macy, Jr., Foundation).

**Spleen**

Dameshek, William. *Hypersplenism and surgery of the spleen.* n.d. (gift of publisher).
Sturgis, C. C. *Hypersplenism.* c1953. (gift of publisher).

**Surgery**

American College of Surgeons. *Surgical forum.* c1953. (gift of publisher).
Lahey Clinic Staff. *Surgical practice of the Lahey Clinic.* c1951. (gift of publisher).

**Tuberculosis**

Drea, W. F. *The metabolism of the tubercle bacillus.* c1953. (gift of publisher).
Solomon, Saul. *Tuberculosis.* c1952. (gift of publisher).

**Miscellaneous**

Bernays, E. L. *Public relations.* c1952. (from Nurses' Association).
Bradley, J. H. *Patterns of survival.* c1952. (gift of publisher).
Calverley, E. T. *How to be healthy in hot climates.* 2nd ed. c1953. (gift of publisher).
Conn, H. F., ed. *Current therapy, 1953.* c1953. (gift of publisher).
Cutting, W. C., ed. *Annual review of medicine.* v. 4. 1953.
*Directory of medical specialists.* v. 6. c1953.
Duncan, G. G. *Diseases of metabolism.* 3rd ed. (gift of publisher).
Galdston, Iago, ed. *The epidemiology of health.* c1953. (gift of publisher).
Hall, V. G., ed. *Annual review of physiology.* v.15, 1953.
Ham, A. W. *Histology.* 2nd ed. c1953. (gift of publisher).
Hiller, Alma. *Practical clinical chemistry.* c1953. (gift of publisher).
Jensen, Julius. *Modern concepts in medicine.* c1953. (gift of publisher).
Macmichael, William. *The gold-headed cane.* c1953. (gift of publisher).
McClellan, W. S. *Physical medicine and rehabilitation for the aged.* c1951. (gift of publisher).
Riese, Walther. *The conception of disease.* c1953. (gift of publisher).
Womack, N. A. *On burns.* c1953. (gift of publisher).

It is with particular pleasure we announce the addition of Dr. Harry Arnold, Jr.'s new monograph to our collection on leprosy. Dr. Arnold has achieved international recognition as an authority in this field, and is highly esteemed locally for his active interest in problems pertaining to this area. Moreover, from our knowledge of his work in the Medical Library, we respect his serious and scholarly approach to the subject, and are proud to place his volume on the shelves alongside the notable contributions of Drs. Mouritz, Muir and Rogers.

* * *

## Medical Library Association Meeting

It was fortunate that Mrs. Hill was able to arrange her vacation trip to include the annual meeting of the Medical Library Association in Salt Lake City, June 16-19. Our library has not been represented at a meeting since 1947, and it was apparent to Mrs. Hill that it is increasingly important for us to have an opportunity to meet and discuss our medical library problems with mainland librarians. Moreover, it is encouraging to be assured that our library is progressing in the right direction, and ranks with the best medical society libraries in cities of comparable size.

The presence of 147 medical librarians at this meeting, plus further meetings of Special Libraries in Toronto and the international meeting in London in July, underscores the continuing growth of medical libraries throughout the world. It is significant that some of the most impressive growth in this field has been made by cost-conscious business firms. There has been a noticeable increase in the size and number of pharmacy libraries maintained by producers of pharmaceuticals. These corporations have found that it is both essential and economical for them to maintain research collections to aid their staffs in experimentation, development and evaluation of new drug products.

All technical libraries visited in western states appear to be booming. The new medical school and medical library at the University of Washington at Seattle is a very busy place, and the new college library (including a veterinary medicine collection) at Washington State College in Pullman is remarkable for its use of modern methods and equipment. It is evident that there is an increased awareness in modern medical men of the utility and importance of the library as a tool for research or a means of keeping updated in a constantly changing world.

It appears that there is a trend, in cities where there is a medical school library, for medical societies to combine their collections with the university medical school collection (turning over most of their research material to the larger institution) and keeping only recent texts and journal files for the use of the society membership. In the case of medical society libraries in cities without medical schools, the favored plan called for extensive development of the library collection, and the seeking of outside support (strictly on a membership basis) from all organizations using, or who may in the future use the medical library. Under such conditions it was recommended that the library be housed in a building of its own.

It was regrettable that leis could not be taken for at least the key personnel present at the MLA meeting. However, one of Mrs. Hill's leis was presented to the new Association President, Miss Dondale. It may have been the effect of the lei—many enquiries were received as to when the Association would be invited to meet in Hawaii.

# BOOK REVIEWS

### On Burns.

Compiled and edited by Nathan A. Womack, M.D., 178 pp., Price $5.50, Charles C. Thomas, 1953.

This small volume contains the information accumulated from a symposium on burns at the University of Iowa last year. It contains a very readable presentation of recent advances in the treatment of burns by such noted authorities as Dr. Sidney Ziffren, Dr. Stuart Cullen, Dr. Truman Blocker, Dr. Altemeier, Dr. Moyer and Dr. Butterfield. Such phases as the open treatment versus the closed treatment of acute burns, problems of infection and enzymatic debridement, salt and water metabolism and the treatment of burn shock are adequately and thoroughly covered. To those engaged in the treatment of burns, this book would be an excellent refresher on the modern trends of burn therapy.

JAMES W. CHERRY, M.D.

### Meniere's Disease.

By Henry L. Williams, M.D., M.S. in Otol., 349 pp., illustrated, Price $7.00, Charles C. Thomas, 1953.

Above all, in this monograph, one is impressed by a good literary style, so rare in medical writing. Henry Williams uses fair judgment towards those whom he considers constructive in their thinking, but uses a sharp pen when he finds faulty argument and misinterpretation of clinical reports. His modest concession to others often disguises a Ciceronian thrust.

In his book, one will find more than a discussion of Menière's disease. For instance, in the author's insistence on clear definitions, he gives an excellent review on such terms as vertigo, dizziness, and giddiness, and always demands clear thinking. The book should engage anyone interested in the subject were it only for the author's discussion of vascular reactions to stress and their relation to tissue sensitivity and immunization. The whole subject of Menière's disease becomes more clear as one grasps the author's explanation of the underlying mechanism of concurrent arteriolar constriction with capillary dilatation.

MAURICE GORDON, M.D.

### The Gold-Headed Cane.

By William MacMichael, M.D., Seventh Edition, Foreword by James J. Waring, M.D., Preface by William J. Kerr, M.D., Introduction by George C. Peachey, 205 pp., 40 illustrations, Price $6.50, Charles C. Thomas, 1953.

> Physic, of old, her entry made
> Beneath th'immense full-bottom's shade;
> While the gilt cane, with solemn pride
> To each sagacious nose apply'd,
> Seem'd but a necessary prop
> To bear the weight of wig at top.
> (WADD, NUGAE CANOROE)

A gold-headed cane looks at British medical practice from 1670 to 1820 through the eyes of the five famous physicians—Radcliffe, Mead, Askew, Pitcairn and Baillie —who successively carried it. What it sees ought to be shared by every thoughtful physician.

The fourteen-year-old tradition of annually awarding a gold-headed cane to that senior medical student at the University of California who manifests the keenest interest in the welfare of his patients is described in detail in the Preface by Dr. Kerr, and the recipients and runners-up, from Warren Bostick in 1939 to John Farquhar in 1952, are listed.

This seventh edition is beautifully printed and bound, and would make a handsome and memorable gift to any medical student.

HARRY L. ARNOLD, JR., M.D.

### Chronic Pulmonary Emphysema.

By Maurice S. Segal, M.D. and M. J. Dulfano, M.D., 180 pp., illustrated, Price $5.50, Grune & Stratton, 1953.

This monograph is a timely one and should be well received by most physicians who are interested in this problem. It is concise enough and yet fairly comprehensive in its scope. The description of the pulmonary function tests is clear and understandable. The authors have a good understanding of the present concept of the physiopathology of this condition. Their suggestions for the treatment are very helpful but do not represent the final answer to this problem.

F. K. LUM, M.D.

### Toxemias of Pregnancy.

By William J. Dieckmann, S.B., M.D., 710 pp., illustrated, Price $14.50, C. V. Mosby Company, 1952.

Because of the rapid advances made in the field of toxemias of pregnancy, a revision of this well-known text is most welcome. The original format has been retained. The book is divided into six sections, namely, 1) history, classification, incidence and pathology of the toxemias, 2) normal and abnormal physiology, 3) etiology of eclampsia, 4) clinical aspects of the toxemias, 5) treatment of the toxemias and 6) maternal and fetal prognosis and prenatal care.

The chapter on "Pathology of Eclampsia" includes the work of Dr. H. Sheehan who is professor of pathology at the University of Liverpool. He has done extensive research in this field and is probably the foremost authority on this subject.

The chapter on "Pathology of the Placenta" contains the contributions of Dr. Bartholomew. His studies on placental infarcts and their role in toxemia are presented in detail.

Various drugs used in toxemia are brought up to date. Veratrum viride is discussed thoroughly; however, no mention is made of the carbo-resins, apresoline, and the methonium group of drugs.

This book is full of valuable information and good advice. The bibliography is rather extensive. An excellent text and reference book for anyone who is interested in toxemias of pregnancy and physiology pertaining to obstetrics.

K. S. Tom, M.D.

### Pathology of the Heart.

Edited by S. E. Gould, M.D., D.Sc., 1023 pp., illustrated, Price $25.50, Charles C. Thomas, 1953.

The editor, with the contributions of thirteen unquestioned experts in the field, presents the morbid anatomy of the heart in a thorough, complete and easily understandable manner. The text is well organized, with chapters captioned and subcaptioned in bold-face type so that various aspects and subjects can be quickly found. There are numerous gross and microscopic illustrations. The text is not confined to pathology alone, but includes normal and abnormal physiology, prognosis, and clinicopathologic correlation. The volume is highly recommended for cardiologists and pathologists and others interested in obtaining the "last word" on any pathologic aspect related to diseases of the heart.

Raid Chappell, M.D.

### Tumors of the Orbit.

By Raymond G. Ingalls, M.D., 410 pp., illustrated, Price $11.50, Charles C. Thomas, 1953.

The data in this excellent monograph will be of great assistance to the ophthalmologist when he is presented with a case of unilateral exophthalmos. The greater part of the material was obtained from specimens in the Pathology Laboratory of the Institute of Ophthalmology of the Presbyterian Hospital and the Head and Neck Clinic of the Memorial Hospital for the Treatment of Cancer and Allied Diseases. The biopsies and specimens of 216 orbital tumors, 27 types, were collected and the salient features of the exhibit are recorded by pictures of patients, photographs of roentgenograms, pictures of gross specimens, photomicrographs of tumor tissues, statistical tables and condensed case reports. This wealth of material magnifies a hundred fold the experiences which normally accrue to an individual in the course of a lifetime of general eye practice.

Harold F. Moffat, M.D.

### Amebiasis.

By Hamilton H. Anderson, M.D., Warren L. Bostick, M.D. and Herbert G. Johnstone, Ph.D., 431 pp., illustrated, Price $11.50, Charles C. Thomas, 1953.

This excellent monograph can be heartily recommended to every practitioner involved in the treatment of amebiasis. The three California authors have presented its pathology, diagnosis and therapy very adequately. The reading of this treatise means a better understanding of the various facets of the disease and leaves one with a proper appreciation of the efficacy of the various forms of treatment available today.

M. E. Stevens, M.D.

### Surgical Practice of the Lahey Clinic.

By Members of the Lahey Clinic, Boston, 1014 pp., Price $15.00, W. B. Saunders Company, 1951.

This new volume, coming out ten years after the first volume, proves to be well worth waiting for. Presented by experts of a noted clinic, the articles are written with authority, and the procedures described are supplemented with excellent photographs and illustrations. The many additions bespeak of the authors' capacity to remain in the forefront of modern surgery. The printing and format are excellent. This volume should be in the library of every practicing surgeon.

Samuel L. Yee, M.D.

### Shame and Guilt.

By Gerhart Piers, M.D. and Milton B. Singer, Ph.D., 86 pp., Price $3.25, Charles C. Thomas, 1953.

This is a compact, easy to read, and excellently presented monograph of Thomas's American Lecture series which includes a psychoanalytical and cultural study of "Shame and Guilt" as titled. The authors did not pretend it to be anything but a monograph—it dissertates and poses a question. It is divided into two parts. The first part is a psychoanalytical study, and the second is a cultural study of "Shame and Guilt." The first part attempts psychoanalytically to differentiate between shame and guilt and the second part attempts rather an ambitious job of dividing the culture into "guilt culture" and "shame culture," leaving the reader with an impression that the study itself is not complete in the minds of the authors. The bibliography is excellent.

Dorothy S. Natsui, M.D.

### The Pharm-Assist Manual.

By A. E. Slesser, B.S., M.S., Ph.D., 167 pp., Price $3.50, C. V. Mosby Company, 1953.

This handy manual, primarily intended for the pharmacy student, also contains some very good information for the busy practitioner. Its arrangement is particularly good, and its terminology is exceptionally clear. It has a definite appeal by virtue of its very simplicity.

Included in its text is a general discussion on "Organic Chemistry," which condenses a whole text book into a few concise pages.

Another interesting feature is inclusion of organic drugs of both the U. S. P. XIV, and N. F. IX, in a convenient alphabetized therapeutic classification.

This small volume should be considered as a reference book and, while it would not be needed daily, its existence should be known so that it can be referred to when the occasion arises.

Clinton D. Summers

### An Atlas of Surgical Exposures of the Extremities.

By Sam W. Banks, M.D. and Harold Laufman, M.D., Ph.D., 391 pp., illustrated, Price $15.00, W. B. Saunders Company, 1953.

This book is a good comprehensive atlas of surgical incisions of the extremities. As a matter of completeness, the author has included many of the simplest as well as the more complicated incisions. The index of the book is complete and easy to use.

This book is well bound and is of the very best quality. The incisions themselves are amply illustrated by photographs. This text is strictly a reference book and should appeal to all surgeons who contemplate surgery on any of the extremities.

B. Allen Richardson, M.D.

### The Nature and Significance of the Antibody Response.

Edited by A. M. Pappenheimer, Jr., 227 pp., Price $5.00, Columbia University Press, 1953.

This symposium serves as an answer for those who have pondered over the whys and whats of antibodies. It is a compilation of the views and investigative studies of some of our renowned authorities. There are still some aspects of the antibody response and formation which remain unsolved; but one has the impression, after completing this book, that a solution to these problems is being gradually achieved.

The titles of the chapters give you an idea of the basic nature of this book and should arouse your interest so that you would want to read the contents. Radioactivity in the antigen-antibody reaction is a relatively new endeavor and the role of radioactivity is adequately discussed.

For an up-to-date review of the immunologic nature and significance of the antibody response, read this symposium.

Clarence Y. Sugihara, M.D.

### Contact Dermatitis.

By George Waldbott, M.D., 218 pp., Price $8.75, Charles C. Thomas, 1953.

The chief contribution of this monograph, written from the point of view of an allergist, is the illustrations. Imprints of dozens of objects and activities were made on body areas by the use of black liquid and the photographs are easily the best and most definitive in print. Unfortunately, we do not often see the resulting lesions so clearly on the patient; but the book gives one a quick reference on numerous possibilities which do not come readily to mind.

The text explanations of mechanism, pathology, and differential diagnosis will not be so interesting to readers as they add nothing new and present opinionated views of many controversial subjects. It is doubtful that many doctors or patients will delve into the extensive history and diagnostic procedures advocated. The steps of investigating the causes of pruritus ani on page 151, and pruritus vulvae on page 157, should be carefully noted by all general practitioners and the table summary of local treatment correlated for stages of the disease on page 181 deserves to be posted on the walls of treatment rooms everywhere. Appendix I, showing principal contact agents and irritants in various occupations, serves as an excellent quick-reference guide to dermatologists and industrial physicians in rapidly suggesting sources of contact dermatitis in the commoner job classifications.

C. V. Caver, M.D.

### Immunity, Hypersensitivity and Serology.

By Sidney Raffel, Sc.D., M.D., 531 pp., illustrated, Price $8.00, Appleton-Century-Crofts, Inc., 1953.

Dr. Raffel has produced an up-to-date treatise on the complex subject of immunity. It represents a prodigious compilation and requires careful reading, as no words are wasted in order to compress the subject into a little over 500 pages.

The examples given are clear and straightforward with a minimum of diagrams. The bibliography is adequate without being redundant. The book falls naturally into four sections. After describing the mechanisms of immunity and hypersensitivity, he discusses individual diseases and how the various mechanisms apply and ends with a description of serology and antigenic systems. Dr. Raffel is completely without bias, as if to say, "No generalization is true—not even this one."

Because the subject is theoretical and not clinical, it cannot be called a "must" book—it is only extremely desirable reading.

James R. Enright, M.D.

### Modern Concepts of Leprosy.

By Harry L. Arnold, Jr., M.D., 105 pp., illustrated, Price $3.75, Charles C. Thomas, 1953.

This monograph brings up to date in a simplified form a considerable amount of the bibliography on leprosy and represents a lot of painstaking work on the part of the author. The chapters are well written, to the point, and do not burden the reader with excess verbiage. The salient features of diagnosis and pathology are well covered. The diagnostic charts are excellent and the illustrations good, but should be in color to accentuate the detail. This book will be of considerable interest to physicians everywhere and a must for those practicing in areas where the disease occurs. The author is to be congratulated on an excellent presentation of the subject.

H. S. Dickson, M.D.

### The Physician in Atomic Defense.

By Thad P. Sears, M.D., F.A.C.P., 308 pp., illustrated, Price $6.00, Year Book Publishers, Inc., 1953.

Sears' book "The Physician in Atomic Defense" is an unusually "sharp" compend on a tremendous new field of endeavor. It is an orderly progressive attack on a problem with clear concise definitions that enable anyone to understand how scientists working independently and together finally arrived at an understanding of nuclear energy. This provided methods for production in commercial amounts and a controlled release of this energy either for research, therapy, or the maximum release in the shape of "bombs."

Any physician who contemplates use of isotopes for diagnosis or treatment will find in this an excellent background for additional training in their use. No one should attempt a course such as that given at Oak Ridge without such a background of knowledge.

Every physician wants to understand the effects of an atomic burst on a population. Ours may be the problem of treating these patients, determining how much radiation, burns or blast they have received. Sears has compiled the best thinking of AEC and civil defense authorities and gives the "HOW, WHAT, WHERE, AND WHEN" to handle the problem.

Like the Bible, it cannot be mastered on first reading. You can read and reread the book many times and profit from each chapter.

Robert B. Faus, M.D.

### Diagnostic Tests in Neurology.

By Robert Wartenberg, M.D., 228 pp., Price $4.50, Year Book Publishers, Inc., 1953.

Medical books are seldom written for easy, pleasurable reading. I find Dr. Wartenberg's small volume just this type—non-technical, clear, simple, full of facts and illustrations. Particularly in detecting and eliciting signs for early nerve and muscular lesions, I believe his little pointers and suggestions are exceedingly helpful. Throughout the book, his emphasis on observation is clearly brought out by means of numerous practical devices, using the handy little articles in one's office.

The general practitioner should have a copy on his desk for reference in his differential diagnosis. For the young doctors desiring to improve their diagnostic acumen, I highly recommend the textbook for their careful perusal and study; and finally, for any doctor: if you have not the time to read the book, do glance over the illustrations.

For just casual reading for any doctor of medicine or anyone interested in medical science, I suggest his spending a few minutes looking over the two Forewords by Sir Gordon Holmes and Dr. Stanley S. Truman and the author's discussion on "Clinic vs. Laboratory" and "Power of Observation" in his introduction. Their comments on clinical diagnosis are certainly valuable in the practice of good medicine.

MON FAH CHUNG, M.D.

### Practical Clinical Chemistry.

By Alma Hiller, Ph.D., 266 pp., 13 tables, Price $6.50, Charles C. Thomas, 1953.

Many times in clinical procedure books, the details are left to the discretion of the laboratory technician, and errors in technique are corrected after much time has been lost by minor mistakes. Any average technician, by following the outlines in Alma Hiller's manual, can expect accurate results with a minimum of difficulty.

The most frequently performed procedures of clinical chemistry are minutely detailed; the explanations of the preparation of solutions and their reactions are thorough and clear; the charts are collections of data that are greatly simplified; and the precision instruments and equipment to be used are adequately described.

This book, with its workable information, is one that can be used every day in the clinical chemistry laboratory.

MARY CONNOR, B.S., M.T.

### Glaucoma—Pathology and Therapy.

By Paul Weinstein, M.D., translated by Julius Foldes, M.D., 295 pp., illustrated, Price $8.00, C. V. Mosby Company, 1953.

This comprehensive and exhaustive monograph effectively presents in one volume the present day worldwide concepts of glaucoma.

The author, himself a renowned clinical ophthalmologist, guides his reader with a deft hand through the diagnosis, classification, frequency and etiology of this disease to a comprehensive discussion of the therapy of glaucoma.

American and British ophthalmologists are grateful to the translator for making this book available in the English language. They will be amply rewarded with many new thought-provoking and documented ideas about practically all phases of this blinding condition.

WILLIAM JOHN HOLMES, M.D.

### Diseases of Metabolism.

Edited by Garfield G. Duncan, M.D., Third Edition, 1179 pp., Price $15.00, W. B. Saunders Company, 1952.

Duncan's book is *the* classic in its field. This third edition has been re-written to keep pace with the rapid advances medicine is making. This book appears voluminous only because it is comprehensive; in reality it is rather concise. The authors have tried very well to bridge the gap between the laboratory worker and the clinician.

Latest information regarding ACTH and cortisone is included in this text as well as similar recent developments in the fields of radioactive isotopes, NPH insulin, vitamin $B_{12}$ and folic acid therapy. The chapters on water and mineral balance are excellent. The bibliography has been carefully selected to be of the most practical value to the clinician.

I have found this book very enlightening and recommend it to every practitioner of medicine.

ROBERT C. H. CHUNG, M.D.

## Also Received

### The Medical Clinics of North America.

May, 1953, New York Number—Prolonged Illness, pp. 629-952, figs. 87-134, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1953.

July, 1953, Nationwide Number—Bedside Management, pp. 953-1,281, figs. 135-169, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1953.

### Surgical Forum.

Clinical Congress of the American College of Surgeons, 1952, 716 pp., Price $10.00, W. B. Saunders Company, 1953.

Papers by about 300 contributors.

### The Metabolism of the Tubercle Bacillus.

By William F. Drea, D.M.D. and Anatole Andrejew, I.C., 448 pp., Price $12.50, Charles C. Thomas, 1953.

An excellent technical manual for investigators.

### Diseases of the Nervous System in Infancy, Childhood and Adolescence.

By Frank R. Ford, M.D., Third Edition, 1216 pp., illustrated, Price $17.50, Charles C. Thomas, 1952.

Third Edition of a highly recommended standard textbook.

### Nervous Transmission.

By Ichiji Tasaki, M.D., 164 pp., illustrated, Price $7.50, Charles C. Thomas, 1953.

Fascinating and fundamental but pretty technical.

### Histology.

Arthur Worth Ham, M.B., Second Edition, 866 pp., illustrated, Price $10.00, J. B. Lippincott Company, 1953.

Excellent for medical students.

### Modern Concepts of Medicine.

By Julius Jensen, Ph.D. (in Medicine) University of Minnesota, M.R.C.S. (England), L.R.C.P. (London), 636 pp., illustrated, Price $11.50, C. V. Mosby Company, 1953.

### The Surgical Clinics of North America.

June, 1953, Lahey Clinic Number—The Neck and Upper Mediastinum, pp. 619-941, figs. 139-265, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1953.

# Territorial Association Report

## CHARTER OF INCORPORATION OF HAWAII MEDICAL ASSOCIATION

*(Amended May 2, 1953)*

ARTICLE I — Name

The corporation heretofore, on July 15th, 1856, duly incorporated by charter granted under the laws of the Kingdom of Hawaii under the name of "The Hawaiian Medical Society," and since 1941 as the "Hawaii Territorial Medical Association," is hereby continued and constituted in perpetuity as a body corporate under the name of "HAWAII MEDICAL ASSOCIATION" with all the rights, benefits, privileges and immunities which now are or hereafter may be secured by law to corporations of this character.

ARTICLE II — Office

The principal office of the corporation shall be at Honolulu, City and County of Honolulu, Territory of Hawaii, but the corporation shall have the power to establish and maintain such other offices within or without the Territory of Hawaii as may be deemed necessary or proper.

ARTICLE III — Purposes; Component Societies

The purposes of the corporation and the objects for which it is organized are, in addition to any others set forth elsewhere in this charter: To federate and bring into one compact organization the entire medical profession of the Territory of Hawaii and to unite with similar state medical societies to form the American Medical Association; to extend medical knowledge and advance medical science and to promote the betterment of public health; to elevate the standards of medical education, and to foster the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the legitimate interests of members of the medical profession and to protect them against imposition; to enlighten and direct public opinion in regard to the problems of medicine, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life; to charter or accredit as affiliates of the corporation, county or other subordinate medical societies or associations (hereinafter referred to as "component societies"), whether incorporated or unincorporated, upon such lawful terms and conditions and with such rights and privileges in relation to this corporation as the by-laws shall provide and to such extent as shall not be prohibited by law.

ARTICLE IV — Membership

Membership in the corporation shall be limited to doctors of medicine. Additional qualifications for such membership may be provided in the by-laws of the corporation, and the manner of admission and expulsion of such members shall be as provided in the by-laws. Such by-laws, among other things, may provide for life, annual, guest, or other classes of membership, and for membership by reciprocity with other medical societies or associations, whether incorporated or unincorporated, and may require as a condition of membership in the corporation, that such members also be members of component societies.

ARTICLE V — Powers

The corporation hereby created shall have power to sue and be sued in any court; to make and use a common seal and alter the same at its pleasure; to maintain offices; to receive, hold, purchase, lease, sell and convey such real and personal property as may be required for the purposes of the corporation; to borrow money and to mortgage or otherwise hypothecate the property of the corporation to secure any of its debts; to appoint such subordinate officers and employees with such titles and with such powers, duties and functions as the business or purposes of the corporation may require; to make, amend and repeal by-laws not inconsistent herewith or with any laws for the management of its property, the admission and classification of members, the payment of entrance fees, dues, and assessments; the election, government and removal of its officers and the regulation of its affairs, and any other matters which may properly be regulated by by-laws under this charter or the laws of this Territory; and, in addition, shall have such other powers as shall be necessary, appropriate or incidental to the exercise of the objects and powers hereinabove enumerated and such other powers as shall be expressly given by law to corporations of this character. The by-laws, among other things, may require that any specified policies or measures or classes of policies or measures, in order to be adopted by this corporation, shall first be approved, or shall be consented to, by each component society or by the House of Delegates, and may provide for and regulate the attendance of delegates and members, and the voting by members, in person or by proxy.

ARTICLE VI — House of Delegates, Council and Officers

The corporate powers, business, and property of the corporation shall be exercised, conducted and controlled by a House of Delegates constituted as hereinafter set forth; provided, that when the House of Delegates is not in session, the Council (as hereinafter defined) shall have, exercise and perform all of the powers, duties, and functions of the House of Delegates, subject to any restrictions contained in the by-laws.

The House of Delegates shall consist of the President, the immediate Past President, the Vice Presidents, (including the President-Elect), the Secretary and the Treasurer of the corporation, and delegates elected by the component societies; each component society shall elect such number of such delegates and for such terms as shall be fixed or provided for in the by-laws.

The Council shall be composed of the President, the immediate Past President, the President-Elect, the Secretary and the Treasurer of the corporation, and such number of additional Councilors as shall be provided in the by-laws. The President-Elect, Secretary, Treasurer and other Councilors shall be elected by the House of Delegates. The Councilors, other than the President, President-Elect, Secretary and Treasurer, shall be elected for such terms that, as nearly as practicable, the terms of not more than one-third of them shall expire during any one calendar year, and the by-laws shall so provide. The Council shall constitute the finance committee of the House of Delegates and shall perform such other

duties as shall be prescribed by this Charter or the by-laws.

The officers of the corporation shall be the said President, President-Elect, Secretary, Treasurer and other members of the House of Delegates, the Councilors, one or more Vice-Presidents, and such other officers as shall be provided for in the by-laws. The terms of all officers shall be as provided in the by-laws, but all officers shall hold office until their successors are elected and take office, unless sooner removed. The House of Delegates by vote of at least two-thirds of all of the members to which it is then entitled may suspend or expel any Delegates, and may suspend or remove any President, President-Elect, Secretary, Treasurer, or other member of the Council. This function may never be exercised by the Council. Any other officer or employee of the corporation may be elected, suspended or removed by the House of Delegates (or when it is not in session, by the Council) unless it is otherwise provided in the by-laws. In the absence or disability of the President, the President-Elect, and after him any Vice-President, in the order of priority or under such conditions as shall be prescribed in the by-laws may perform the duties of the President. The duties of all officers and employees of the corporation, in addition to those prescribed by this charter, shall be prescribed in the by-laws. All members of the House of Delegates and all other officers shall be residents of the Territory of Hawaii, except as may be otherwise provided in the by-laws in conformity with the laws of this Territory, and the names and places of residence of all such officers shall be registered in the office of the Treasurer of the Territory of Hawaii from time to time upon their election or appointment.

ARTICLE VII — Filing of By-Laws

A copy of all rules, regulations and by-laws of the corporation and of all amendments thereof shall be filed with the Treasurer of said Territory within fourteen days after the adoption thereof.

ARTICLE VIII — Non-stock Corporation

The corporation is not organized for profit and it shall not issue certificates of stock or other evidence of ownership of its property, and no part of its assets, income or earnings shall be used for dividends, or otherwise withdrawn or distributed to any of its members, except upon liquidation of its property in case of corporate dissolution; but it may issue such evidences of membership, life, annual or otherwise, as it may deem proper and appropriate.

ARTICLE IX — Limited Liability

The property of the corporation shall alone be liable for the payment of its debts and liabilities, and no member of the corporation shall be liable for any of such debts and liabilities beyond the unpaid amounts, if any, which may be owing from him to the corporation for any fees, dues or assessments theretofore validly levied or assessed against him pursuant to this charter and the by-laws of the corporation.

ARTICLE X — Law Applicable

This charter and the corporation hereby created shall be subject to all existing laws and to all laws, whether amendatory, repealing or otherwise, that may hereafter be enacted and applicable to charters and corporations of this character.

ARTICLE XI — Amendments

This charter may be amended at any time by vote, in person or by proxy, of a majority of all of the then members in good standing of the corporation at a meeting duly called and held for that purpose, and subject to compliance with all applicable provisions of law.

## BY-LAWS OF HAWAII MEDICAL ASSOCIATION

*(Amended May 2, 1953)*

CHAPTER I — Component Societies

Section 1. All county medical societies now in affiliation with this Association or those which may hereafter be organized in the Territory, which have adopted principles of organization not in conflict with these by-laws, shall, on application, receive a charter from and become a component part of this Association.

Section 2. Only one component medical society shall be chartered in any island of the Territory.

Section 3. Charters shall be issued by the House of Delegates, and shall be signed by the President and the Secretary. The House of Delegates may revoke the charter of any component society whose actions are in conflict with these by-laws.

Section 4. Each component society shall have general direction of the affairs of the profession in its jurisdiction.

Section 5. Each component society shall keep a roster of its members, and of the non-affiliated licensed physicians of its jurisdiction, recording the full name, address, college and date of graduation, date of license to practice in the Territory, and such other information as may be deemed pertinent.

Section 6. Each component society shall be responsible for collecting from its members such dues and assessments as the House of Delegates is empowered to levy against such members, and shall remit same to the Treasurer.

Section 7. When a member in good standing in a component society moves to another jurisdiction in the Territory, his name, on request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves.

Section 8. Each component society shall be entitled to send to the House of Delegates each year one delegate or his alternate for every twenty-five members, and one for each fraction thereof, but each component society which has otherwise complied with the requirements set forth in this Chapter shall be entitled to at least one delegate. At a meeting prior to the annual meeting, each component society shall elect such delegates and alternates.

Section 9. The Secretary of each component society shall send to the Secretary of the Association at least 30 days before the annual meeting: (a) a list of delegates and alternates, (b) a roster of its officers and members, (c) a list of non-affiliated physicians in its jurisdiction.

Section 10. Any county society which fails to pay its assessment, or make the reports required, 30 days prior to the annual meeting, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or the House of Delegates.

CHAPTER II — Membership

Section 1. Every doctor of medicine holding a valid unrevoked license to practice medicine in the Territory of Hawaii, who is a member in good standing of a component society shall be a member of the Association.

Section 2. Each component society shall judge the qualifications of its members, but as such societies are the only portals to the Association and to the American Medical Association, every reputable and legally licensed doctor of medicine shall be eligible to membership.

Section 3. Any person whose name has been dropped from the membership roll of a component society shall not be entitled to any of the rights or benefits nor shall

he be permitted to take part in any of the Association's proceedings until he has been relieved of such disability.

Section 4. Any physician who may feel aggrieved by the action of a component society in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and the Council shall report its findings and recommendations to the component society.

### CHAPTER III — Officers

Section 1. The officers of the Association shall be the President, one or more Vice-Presidents, the Secretary and the Treasurer.

Section 2. Election and Tenure of Office. (a) At each annual meeting, a President-Elect shall be elected. The President-Elect shall be ex-officio a Vice-President, and a voting member of the Council and the House of Delegates and shall act as President in the absence of the President during the President's active term of office. The President-Elect elected during any calendar year shall commence his active term of office as President as soon as his own successor has been elected, and he shall hold office until the annual meeting to be held the year next succeeding and until his successor is installed, unless sooner removed; provided: (1) that in the event of the death, resignation or removal of the President before his active term expires, the President-Elect shall become President and his active term as such shall commence immediately; and (2) that, in the event that the Association for any reason shall fail to hold an annual meeting before the end of May in any year, the President-Elect elected at the previous annual meeting shall nevertheless take office as President on June 1 or as soon thereafter as possible.

(b) In 1955, the House of Delegates shall elect a Secretary for one year and a Treasurer for two years. Thereafter the Secretary and Treasurer shall be elected in alternate years for a two-year term.

(c) The President of the component societies and the President-Elect shall be ex-officio Vice-Presidents of the Association.

(d) All officers of the Association, except as otherwise provided in these by-laws, shall hold office until their successors are elected and installed, unless sooner removed.

(e) In the event of the President's death, resignation, removal or absence, and if the President-Elect shall have died, resigned or been removed or shall be absent, the House of Delegates or, if they are not in session, the Council shall elect one of the remaining Vice-Presidents in his place, temporarily or otherwise, as the situation may require.

(f) In the event of a vacancy in the office of Secretary or Treasurer, the President shall make an appointment to fill the vacancy until the next annual election.

Section 3. Functions. (a) *President.* The President shall preside at all meetings of the Association; he shall appoint and be a member of a Scientific Program Committee, a Legislative Committee, and any other committees, the manner of whose appointment is set forth in Chapter VIII or is not otherwise provided for; he shall deliver an address at the annual meeting, and shall perform such other duties as custom and parliamentary usage may require. He shall visit, as far as practicable during his term of office, the various component societies of the Territory. He shall be ex-officio a voting member of the Council, the House of Delegates, and of every committee. He shall continue to be a voting member of the Council and the House of Delegates for one year following his retirement as President.

(b) *President-Elect.* The President-Elect shall be ex-officio a Vice-President, and shall act as President in the absence of the President during the President's term of office. He shall be a voting member of the House of Delegates, of the Council and of every committee.

(c) *Vice-Presidents.* The Vice-Presidents shall assist the President in the discharge of his duties, and shall be members of the House of Delegates with full voting and other rights in that body. The President-Elect, before taking office as President, shall have all of the powers of the President when acting for him as provided in these by-laws.

(d) *Treasurer.* The Treasurer shall demand and receive all funds due the Association, together with bequests and donations; he shall make such payments as are authorized by the Council; he shall keep an accurate account of all money received and expended, supported by vouchers, and shall render the Council at each annual meeting a statement of accounts together with a budget for the coming year; he shall subject his accounts to such examination as the House of Delegates may order, and he shall give a bond in the sum of $1,000.00, the fee to be paid by the Association. He shall be ex-officio a voting member of the Council and of the House of Delegates.

(e) *Secretary.* The Secretary shall attend all meetings of the Association. He shall keep either personally or by the delegation of his duties to the Executive Secretary minutes of their respective proceedings; be custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer; keep account of and promptly turn over to the Treasurer all funds of the Association which come into his hands; provide for the registration of members and delegates at the annual meeting; keep a register of the members of the Association by counties and a roster of non-affiliated physicians in the Territory; conduct the official correspondence of the Association, notifying members of meetings, officers of their election, and committees of their appointment and duties; employ such assistants as may be ordered by the House of Delegates; make an annual report to the House of Delegates; supply all component societies with the necessary blanks for making their annual reports. In cooperation with the Scientific Program Committee, he shall prepare and issue all programs. He shall file in the office of the Treasurer of the Territory of Hawaii the names and places of residence of all officers of the Association from time to time upon their election or appointment, and a copy of all rules, regulations and by-laws of the Association and of all amendments thereof within fourteen days after the adoption thereof. He shall be ex-officio a voting member of the Council and the House of Delegates.

Section 4. The President, the President-Elect, the Secretary and the Treasurer shall be ex-officio members of the Council, and of the House of Delegates. Each shall have a vote in these bodies and be counted in determining a quorum.

Section 5. The President and President-Elect shall be ex-officio voting members of all committees but shall not be counted in determining a quorum.

### CHAPTER IV — House of Delegates

Section 1. Election and Tenure of Office. (a) The House of Delegates shall consist of (1) Delegates or their alternates, elected by the membership of the component societies in the ratio of one delegate and one alternate for every twenty-five members, and one for each fraction thereof; (2) the President, the President-

Elect, the Secretary and the Treasurer of the Association, elected by the House of Delegates as hereinabove provided, and (3) the Vice-Presidents ex-officio.

(b) All members of the House of Delegates shall hold office until their successors are elected and installed.

(c) The officers of the Association shall be the officers ex-officio of the House of Delegates.

Section 2. Functions. The corporate powers, business and property of the Association shall be exercised, conducted and controlled by the House of Delegates.

(a) It may issue charters to component societies.

(b) It shall have power to revoke charters of component societies.

(c) It may levy such assessments as it deems necessary to carry on the business and functions of the Association, not to exceed $25 per member per year without referendum.

(d) It shall approve all memorials and resolutions issued in the name of the Association before they shall become effective and be publicized.

(e) It shall have authority to appoint committees for special purposes. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

(f) It shall elect a Delegate and Alternate to the House of Delegates of the American Medical Association in accordance with the Constitution and By-laws of that body.

(g) At its annual meeting, it shall set the time and place for the annual meeting for the coming year.

(h) It shall encourage postgraduate and research work and shall endeavor to have the results utilized and intelligently discussed in the county societies.

(i) All questions of an ethical nature brought before the House of Delegates shall be referred to the Council without discussion.

(j) When a general referendum on any question pending before the House of Delegates is ordered by the general membership, as provided for in Chapter VI, Section 1 (f), the Secretary shall submit such question to the entire membership, who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Association, a majority of such votes shall determine the question and be binding on the House of Delegates.

(k) The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding subsection, and the result shall be binding on the House of Delegates.

## CHAPTER V — The Council

Section 1. The Council shall consist of six Councilors, and the President, the immediate Past President, the President-Elect, the Secretary and the Treasurer.

Section 2. Election and Tenure of Office. (a) The Councilors, other than the President, the President-Elect, the immediate Past President, the Secretary and the Treasurer, shall serve for a period of three years, two being elected annually by the House of Delegates.

(b) No person except the President, immediate Past President, President-Elect, Secretary and Treasurer shall hold the offices of Councilor and Delegates simultaneously.

(c) Councilors shall hold office until their successors are elected and installed, unless sooner removed.

(d) The officers of the Association shall be ex-officio the officers of the Council.

(e) No Councilor shall serve for more than two consecutive terms or a maximum of three terms.

Section 3. Functions. (a) The Council shall serve as the Executive Body of the Association between sessions of the House of Delegates, as the Board of Censors of the Association, and as the Finance Committee, and shall carry out such other functions as may be delegated to it by the House of Delegates.

(b) As the Executive Body it shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary.

(c) It shall assist in the maintenance of a medical library and shall from time to time, and at least once a year, appropriate funds for this purpose, subject to the approval of the House of Delegates. In consideration of this financial support, the library shall be at the service of any member of the Association.

(d) As the Board of Censors, it shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to the Association. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, and shall report its findings and recommendations to the component society.

(e) In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, the Councilors, both as a Board and as individuals, shall precede all such hearings by efforts at conciliation and compromise.

(f) As the Finance Committee it shall order an annual audit of the accounts of the Treasurer and other agents of the Association and present a statement of the same, together with a budget for the coming year, in its annual report to the House of Delegates. All monies received by the Council and its agents, resulting from the discharge of duties assigned to them, must be paid to the Treasurer.

## CHAPTER VI — Meetings

Section 1. Annual Meetings of the General Membership. (a) *Time and Place.* The Association shall hold an annual meeting, attended by registered members and guests, in April or May, and at such time and place as have been fixed by the House of Delegates.

(b) *Program.* The program for such annual meeting shall be devoted to scientific papers, clinics and discussions; scientific and commercial exhibits, and discussion of such matters as may be properly brought before it. Provisions may be made for a division of the scientific work into appropriate sections.

(c) *Registration.* Each member in attendance at the annual meeting shall enter his name on the registration book, indicating the component society of which he is a member. When his right to membership has been verified and he has paid his registration fee, he shall receive a badge. No member shall take part in any of the proceedings of the annual meeting until he has complied with the provisions of this section.

(d) *Presiding Officer.* The President, the President-Elect, or one of the remaining Vice-Presidents, as the situation may require, shall preside over the annual meeting.

(e) *Referendum.* By a two-thirds vote of those present, the members may order a general referendum

on any question. When so ordered, the Secretary shall submit such question to the entire membership, who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Association, a majority of such votes shall determine the question and be binding on the House of Delegates.

(f) *Ethics.* All questions of an ethical nature brought before the general meeting shall be referred to the Council without discussion.

Section 2. Special Meetings. Special meetings, either of the Association or of the House of Delegates, may be called by the President, and shall be called by the President on petition of three Delegates or twenty members of the Association.

Section 3. House of Delegates Meetings. (a) *Time and Place.* The House of Delegates shall meet during the annual meeting, and upon the call of the President.

(b) *Credentials.* Delegates or alternates shall present their credentials to the Secretary and be identified. One duly elected alternate, designated by the President of his component society may be seated in the place of each absent delegate from the same component society.

(c) *Quorum.* A majority of the authorized membership of the House of Delegates shall constitute a quorum.

(d) *Proxies.* Proxies shall not be recognized.

(e) All meetings of the House of Delegates shall be open to the members of the Association.

(f) *Order of Business.* The first meeting of the House of Delegates at each annual meeting shall be the first order of business of the general membership meeting, and the business of the Association shall be taken up in the following order as far as practicable: reports of component societies, reports of the Council, the Secretary, and Treasurer; the President's address; reports of Committees; presentation of new business. The House of Delegates may adjourn and reconvene from time to time thereafter as may be necessary to complete its business, provided that the hours shall conflict as little as possible with the general meeting, and provided that the election of officers and Councilors shall be the first order of business after the reading of the minutes on the second day of the annual meeting, followed in appropriate years by the election of a delegate and alternate to the American Medical Association, determination of time and place of the next annual meeting, report of the Finance Committee, adoption of resolution and other necessary actions.

Section 4. Council Meetings. (a) *Time and Place.* The Council shall meet, if at all possible, on the day preceding the annual meeting and at such other times as necessity may require, during the annual meeting upon the call of the President. The Council shall meet when necessary, during the year, at the call of the President.

(b) *Quorum.* Five members of the Council shall constitute a quorum. In the event of the inability of any Councilor to attend a meeting of the Council, the President of the Association, with the approval of the president of the component society concerned, may appoint an alternate in his stead.

CHAPTER VII — Election of Officers and Councilors

Section 1. The officers, other than the Vice-Presidents, and the Councilors shall be elected by the House of Delegates at the annual meeting.

Section 2. All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.

Section 3. No person shall be eligible for any elective or appointive office in the Association unless he shall be in good standing at the time of his election or appointment.

Section 4. No person except the President, immediate Past President, President-Elect, Secretary and Treasurer, shall hold the offices of Councilor and Delegates simultaneously.

Section 5. Officers elected at the annual meeting shall be installed and shall assume office immediately.

CHAPTER VIII — Committees

Section 1. The committees of the Association shall include: (a) a Scientific Program Committee; (b) a Legislative Committee; (c) a Committee on Meeting Arrangements; (d) a Cancer Committee; (e) a Diabetes Committee; (f) a Health Education Committee; (g) a Postgraduate Committee; (h) a Public Service Committee; (i) a Nominating Committee; and (j) an Industrial Relations Committee. Such committees shall be appointed by the President.

Section 2. The Advisory Committees shall include Committees on: (a) Crippled Children; (b) Maternal and Child Health; (c) Tuberculosis; (d) Venereal Disease; (e) Chronic Illness; (f) Heart Disease; (g) Radioactive Materials; (h) Physical Therapy; and (i) Woman's Auxiliary. Such committees shall be appointed by the President.

Section 3. The Scientific Program Committee shall consist of the President, the immediate Past President, the President-Elect, and such other members as the President deems necessary, including at least one general practitioner and the chairman of the Postgraduate Committee. It shall determine the character and scope of the scientific proceedings for each session, and the division of the scientific work into appropriate sections. It shall prepare a program for each annual meeting to be issued at least thirty days prior to the meeting.

Section 4. The Legislative Committee shall consist of at least five members in addition to the President, the immediate Past President, the President-Elect, and the Chairmen of the Legislative Committees of the Component Societies. Under the direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of public health and of scientific medicine. It shall keep in touch with professional and public opinion, and shall endeavor to shape legislation so as to secure the best results for the whole community.

Section 5. The Committee on Meeting Arrangements shall be composed of members from the component society of the county in which the annual meeting is to be held. It shall provide suitable accommodations for the meeting places of the Association, of the House of Delegates, and of their respective committees, and shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Secretary for publication in the program, and shall make additional announcements during the session as occasion may require.

CHAPTER IX — Funds and Expenses

Section 1. Annual dues shall be $25.00 per regular member per year to be collected from each component society.

Section 2. The annual subscription price for the HAWAII MEDICAL JOURNAL shall be collected in like manner.

Section 3. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates.

Section 4. The list of members furnished by the com-

ponent societies at the annual meeting shall constitute the basis of assessment of dues against the component society. Only those members excused from payment of all dues to their component society may be excused from payment of dues to the Association.

CHAPTER X — Fiscal Year

The fiscal year of the Association shall be from the first of March to the end of February.

CHAPTER XI — Miscellaneous

Section 1. No address or paper before the Association, except those of the President and invited speakers, shall occupy more than twenty minutes in delivery; and no member shall speak longer than five minutes, nor more than twice, on any subject except by unanimous consent.

Section 2. All papers read before the Association or any of the sections shall become its property and may not be published in whole or in part except by prior arrangement with the Scientific Program Committee. Each paper shall be deposited with the Secretary when read.

Section 3. The deliberations of the Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with the Charter and By-laws.

Section 4. The Principles of Medical Ethics promulgated by the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER XII — Amendments

These by-laws may be amended at any meeting of the Association by a majority vote of the membership, in person or by proxy, provided that notice of the substance of any proposed amendment shall be mailed either to each member of the Association, or to each component society, at least sixty days prior to the date of the meeting at which the vote is taken; provided further, that after such notice, changes in such proposed amendments may be adopted at the meeting without further notice to the members.

## MINUTES OF COUNCIL MEETING

**Thursday, August 6, 1953 at 7:30 p.m.**
**Mabel Smyth Auditorium**

*Present:* Dr. Chung-Hoon, chairman; Drs. N. P. Larsen, Ito, Gotshalk, Ferkany (Maui), Homer Benson, Yuen (Hawaii); also Drs. Hartwell, Homer Izumi, Yamauchi, Waite, White, R. K. C. Lee, Dodge, and Durant. Dr. Chung-Hoon announced that, with the consent of Dr. Tompkins, Dr. Ferkany had been appointed to substitute as Councillor from Maui for this meeting.

*New Orleans Post Clinical Tour:* The New Orleans Graduate Medical Assembly meets yearly and would like to come to Hawaii for a post clinical tour in March, 1954, with a meeting in Honolulu on March 27. Dr. Chung-Hoon said that plans were being made for a light scientific program in which the New Orleans doctors would be invited to participate. Dr. Larsen might talk on plantation medicine or the history of medicine in old Hawaii. Perhaps there might be a brief illustrated talk on Hansen's disease, and perhaps Dr. Gebauer might show his surgical movie. Dr. Larsen stressed the need for determining in advance the exact details of their program. The Postgraduate Committee will be responsible for the plans.

*AMA Report:* Dr. Hartwell reported that he took pineapples and 36 orchid leis to the meeting, which were well received.

Dr. Paul Hawley of the American College of Surgeons was quoted as having made certain derogatory remarks on fee splitting, etc. Eleven resolutions were presented on the subject. The AMA recognized that a certain amount of gouging and unethical procedures exist and that it is the duty of the medical profession to rid itself of these evils.

The AMA took a stand that a veteran who can afford private medical care should pay for acute non-service connected disabilities. Chronic illnesses, such as neurological, psychiatric and tubercular cases, might remain under Veterans' Administration care. This problem is up to Congress to solve.

Dr. John Cline presented a detailed survey of osteopathy in relation to medicine. It was recommended that medicine should cooperate more with osteopathy since the latter now has so little remaining of the "cult." However, the Delegates thought one more year should elapse before making a decision.

It is anticipated that 10,000 will register for the AMA meeting in San Francisco next June. Plans are being formulated for a postconvention tour to Hawaii, which would bring several hundred people to the Islands. We could have registration with payment of a fee, and brief scientific meetings. We should seek the active assistance of the Hawaii Visitors Bureau. We should also write the AMA and find out the details.

Dr. Hartwell said he believed this would be his last trip to the AMA as delegate, since he hoped Dr. Izumi would go in December. He expressed his appreciation to the Council and the Medical Association for the privilege of representing them.

Dr. Izumi reported in addition to attending the AMA meeting, he had looked into business operations of various county medical societies, and felt encouraged to develop a better business and public relations program in Honolulu. Definite progress is being made by the Public Service Committee and several likely candidates are under consideration.

Dr. Hartwell said he was firmly convinced that two men should go to AMA annual meeting with full fare paid and that one man should attend the interim session with full fare paid. He was reassured that this was in accordance with the wishes of our House of Delegates.

Dr. Ito raised a question about Social Security for doctors and asked why the AMA is opposed to it. Dr. Hartwell replied that the AMA is trying to push legislation to exempt from taxation funds set aside by doctors themselves for retirement and to get tax exemption for expenses of doctors taking postgraduate medical courses. The AMA is opposed to increasing government participation in personal finances, which would expand the Social Security System, and feels that it is not geared to the earning pattern of most doctors, for very few of them retire at 65.

**ACTION: On motion of Dr. Ito, duly seconded, the Council accepted the AMA delegates' report.**

*Malpractice Insurance:* Mr. Edgar A. Kudlich, President of the Oahu Insurance Agency, Ltd. and formerly with the Home Insurance Company, described to the Council a group malpractice insurance policy available

on an individual basis through Lloyd's of London. The policy would be issued at a specified limit for the entire group of $150,000 liability. He explained the rates, which are considerably lower than the doctors are now paying here.

**ACTION: Dr. Yuen moved that the Council request the Honolulu County to investigate the group malpractice insurance policy offered by Lloyd's of London. The motion was seconded by Dr. Gotshalk and passed.**

*Finances:* The Treasurer's report was presented. Dr. Hartwell spoke of the importance of supporting the AMA Post Convention Tour.

**ACTION: Dr. Benson moved that a committee be appointed to make arrangements for the AMA Post Convention Tour. The motion was seconded and passed.**

The National Society for Medical Research, to which we contributed $25 last year, requested further financial support.

**ACTION: On motion of Dr. Yuen, seconded by Dr. Ferkany, the Council voted to contribute $25 to the National Society for Medical Research.**

*Mabel Smyth Building:* A letter from Dr. J. Warren White, Secretary of the Board of Management of the Mabel L. Smyth Memorial Building, was read. The Board is faced with a serious financial problem because auditorium rentals have decreased and there is not sufficient income to operate the building. The $10,000 surplus has already been depleted to $9,000 and must be further decreased unless the office rentals are considerably increased and other steps are taken to produce funds for maintenance, repairs, and depreciation. Dr. Waite emphasized the urgent need for immediate action if the doctors wish to continue to occupy the premises. Much discussion followed. It was moved by Dr. Larsen, seconded by Dr. Benson, that we accept the recommendation for next year. This motion was later tabled on motion of Dr. Benson, seconded by Dr. Ferkany. Eventually the following motion passed with a vote of 5 to 1 (Dr. Gotshalk voted against the motion because he did not feel the Library should be charged rent):

**ACTION: Dr. Ito moved, seconded by Dr. Larsen, that the Council endorse the recommendations of the Board of Management of the Mabel Smyth Building as presented in Dr. White's letter of July 29, 1953.**

*Rehabilitation Center:* Dr. Chung-Hoon reminded the Council that a proposed Rehabilitation Center at Children's Hospital had been brought to the attention of the House of Delegates last May 2 on Maui and approved by them. Dr. Yamauchi and Dr. White said the need for a rehabilitation center had been felt by various health agencies for some time. Dr. Dodge told how the Children's Hospital Center had originated and developed. The chairman said he felt the Council should know that this rehabilitation service had been established and should be aware of a certain amount of existing friction. After much discussion, the following recommendation was made:

**ACTION: Dr. Gotshalk moved that the Council inform the President of the Honolulu County Medical Society that the House of Delegates in a meeting on Maui on May 2, 1953 supported the rehabilitation program in which Children's Hospital was to provide space and personnel and the National Foundation for Infantile Paralysis was to provide funds for training personnel for the rehabilitation program. It was the Council's belief that any difficulties which may have arisen in connection with the rehabilitation program might be resolved by having interested representative medical members appointed to the medical advisory board of the rehabilitation center at the Children's Hospital. The motion was seconded by Dr. Ferkany and passed.**

*Adjournment:* The meeting adjourned at 11:50 p.m.

SAMUEL L. YEE, M.D.
*Secretary*

# UMI MAKAHIKI I HALA*

A critical shortage of hospital beds for tuberculosis patients exists in the Territory. Although this situation exists to some extent on the other islands, the major problem is found on Oahu. The facilities of Leahi Hospital, intended to provide for the hospitalization of the tuberculous on this island, cannot meet the existing needs. This situation, which was apparent to some degree before the war and has become increasingly serious since December 7, 1941, can be attributed to a great extent, directly or indirectly, to the effect of the war upon the community.

H. H. WALKER, M.D.
Director, Leahi Hospital

Before major hospital construction is undertaken in Honolulu someone, preferably an outsider with no attachment to any local institution, should make a detailed survey of the community's present and future hospital needs to determine how such construction can best meet the needs of the community. All local people interested in the problem are attached to one hospital or another and will be swayed by such an attachment. An outsider, trained in hospital management, should be able to determine after a survey the necessary number of beds in each category and where they should be placed to result in the greatest efficiency. His opinions, of course, would not be binding upon the trustees and directors of these institutions, but such advice should certainly be sought before large sums of money, most of it probably tax money, are expended. Up to now Honolulu hospitals have grown like Topsy, without planning for the future. It is time that an over-all plan is adopted.

H. L. ARNOLD, M.D.
Medical Director, O.C.D.

You will all know the position that the medical profession of Honolulu has earned in medical affairs of the nation; in all parts of the United States one hears favorable comments on its work, not only at the time of the attack, but the year before and since. I have visited many blood banks, and I found none superior to our own, the special feature of our blood bank being the borrow-repay method. It seems logical that the blood bank should be promoted on a peace-time basis.

F. J. PINKERTON, M.D.

*Ten years ago. From Volume 3, Number 1, September-October, 1943.

# COUNTY SOCIETY REPORTS

## IN MEMORIAM

The Hawaii County Medical Society, after many years of freedom from visits of the grim reaper, suddenly lost two of its older members, Dr. Walter James Seymour of Kona and Dr. Clyde Lincoln Phillips of Hilo, in the short space of five days.

Both were educated at the University of Wisconsin and obtained their medical degree at the same time from Northwestern University, interned at The Queen's Hospital, came to the Island of Hawaii on completion of their internship, and were very close friends throughout the years.

Both were general practitioners, sincerely interested in their patients, for a period of twenty-three years. Both were past presidents of the Hawaii County Medical Society and had devoted a great deal of their time to medical affairs.

Their loss will be keenly felt by their colleagues and their patients.

Our deepest sympathy is extended to their wives and children in the hope that time will ease their grief.

### DR. CLYDE LINCOLN PHILLIPS 1899-1953

Dr. Clyde Lincoln Phillips was born at Rock River, Wisconsin on March 12, 1899, the son of William Henry and Jessie Wood Phillips.

He married Melba Larramore on December 22, 1930 and they had three daughters, Janet Luree, Patricia Ann, and Nina.

He received his high school education at Fond Du Lac and at Ripon, Wisconsin. He did his premedical work at the University of Wisconsin, graduating with a B.S. degree in 1926. In 1928 he completed the medical course at Northwestern University Medical School.

He first came to Hawaii in July 1928 to intern at The Queen's Hospital. On January 1, 1930, he came to Hilo and established himself in the practice of medicine.

He has served as physician for Hawaiian Commercial and Sugar Co., Hawaiian Agricultural Co., Hakalau Sugar Co., Laupahoehoe Sugar Co., and Olaa Sugar Company.

Dr. Phillips was a member of the Phi Chi medical fraternity and his hobby was golf.

### DR. WALTER JAMES SEYMOUR 1903-1953

Dr. Walter James Seymour was born on May 26, 1903 at Chefoo, China. He was the son of Walter Frederick and Mary Ada Crochenour Seymour.

He married Sadie Smythe on July 15, 1933 at Kohala, Hawaii. They had four sons, Walter Frederick, Randolph Smythe, Scott, and Russel.

He attended the China Inland Mission School at Chefoo and Shanghai American School, Shanghai, China. He graduated from the University of Wisconsin with a B.S. degree in 1925 and completed his medical curriculum there in 1928. He served his internship at The Queen's Hospital during the years 1928 and 1929. After finishing his internship, he came to the Island of Hawaii and established himself in private practice at Holualoa, Kona, where he remained until his death.

Dr. Seymour was Government Physician for North Kona and was a member of the American Medical Association. He was also past president of Kona Lions Club. His hobbies were stamp collecting and bee culture.

## KAUAI COUNTY MEDICAL SOCIETY

The regular meeting of the Kauai County Medical Society was held on June 9, 1953 at the G. N. Wilcox Hospital medical library. The meeting was called to order by Dr. Ishii, president, at 7:40 p.m. Other members present were Drs. Boyden, Goodhue, Wallis, Fujii, Brennecke, Masunaga, Kim, Cockett, and Sykes. Guests were Dr. Boudreau, Resident Physician; Mr. Brainard and Mr. Porter of the United States Life Insurance Company, and representatives from the Kauai Pineapple Management.

Mr. Brainard and Mr. Porter described the recently negotiated Pineapple Medical Plan and answered questions from the members present regarding this prepayment medical plan. The Pineapple Medical Plan involves 8,000 employees and 14,000 dependents.

Meeting was adjourned at 10 p.m.

* * *

The regular meeting of the Kauai County Medical Society was held on July 17, 1953 at the G. N. Wilcox Memorial Hospital medical library. The meeting was called to order at 8:00 p.m. Members present were Drs. Wallis, Cockett, Goodhue, Fujii, Kim, and Yamauchi. Guests present were members of the Advisory Committee on Maternal and Child Health consisting of Dr. Satoru Nishijima, Chairman, Dr. Bowles, Dr. L. T. Chun, Dr. T. Nishigaya, Dr. Walsh, Dr. Wong and Dr. Knox.

The evening was devoted to the meeting of the Advisory Committee on Maternal and Child Health with Dr. Nishijima presiding.

Dr. Chun presented two pediatric case histories. Dr. Cockett and Dr. Wallis each presented a maternal case history. Interesting discussions followed these case presentations.

The meeting was adjourned at 9:40 p.m.

RICHARD M. YAMAUCHI, M.D.
*Secretary*

# NOTES AND NEWS

## PERSONALS

The Straub Clinic announces the return of **Dr. Harold M. Sexton.** Dr. Sexton was a former intern at Queen's Hospital and was also in practice with his father in Hilo. He spent 7 months in the pediatric department of Tripler Army Hospital, one year pediatric residency at the University of California Hospital followed by a year as resident at Children's Hospital, Oakland, California. Friends of Dr. and Mrs. Sexton's are delighted to hear that the family has adopted a 2½ year old boy and a 3½ year old girl.

**Dr. Richard S. Dodge** announces the association of **Dr. Richard S. F. Lam** at 305 Royal Hawaiian Avenue. **Dr. Vernon Boido** is now associated with **Dr. John M. Felix** at 311 South Vineyard Street.

**Dr. K. S. Chang,** released after two years of Army service in Japan and Korea, resumed service with the City and County Emergency Hospital beginning July 13, 1953.

**Dr. Dorothy Kemp** has been appointed as assistant Chief of the Bureau of Venereal Disease and Cancer Control of the Territorial Health Department. She will continue as Health Officer for the County of Kauai.

The editors of the HAWAII MEDICAL JOURNAL, along with the Medical Fraternity of Hawaii Nei, are justly proud of **Dr. J. Warren White,** Chief Surgeon of the Shriners' Hospital for Crippled Children for his recent election as president-elect of the American Orthopedic Association.

**Dr. W. B. Herter** announces the reopening of his Kailua office at 507 Uluhau St., in addition to his office in Waikiki.

**Dr. Henry Gotshalk** and **Dr. Robert Faus** have been reappointed by Gov. Samuel Wilder King to the Territorial Board of Health.

**Dr. and Mrs. Frank L. Pleadwell** returned from an 8 months trip of several continents. They visited New Zealand, Australia, South Africa, England and the Mainland U.S.A.

New Surgeons: Four well known, well trained and well liked young surgeons announce the opening of their offices for the practice of general surgery:

**Dr. Grover Batten, Jr.** is a graduate of Punahou School and Washington & Lee University. He received his M.D. from Johns Hopkins University School of Medicine. He interned at the Cincinnati General Hospital. Dr. Batten was called to active duty in 1943 and served until 1946, attaining the rank of Major. He returned to Honolulu in 1947 and became assistant resident and later chief resident in surgery at The Queen's Hospital. From January 1950 through December 1952, he was resident surgeon at The Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York and the National Cancer Institute, Washington, D.C. Dr. Batten is certified by the American Board of Surgery. He is married and has two children.

**Dr. Edward Boone** has been on the staff of the South Shore Community Hospital for the past year and has now joined the Alsup Clinic. Dr. Boone is certified by the American Board of Surgery.

**Dr. John F. Chalmers** spent the last year as a resident in surgery at the Stanford University Hospital. He has returned to the Medical Group.

**Dr. Yasuyuki Fukushima** was with the Army Medical Corps and served as Chief Surgeon with the 64th Field Hospital. Dr. Fukushima is a graduate of the University of Hawaii and the Washington University Medical School in St. Louis. He served his internship and surgical residency at the Barnes Hospital in St. Louis.

**Dr. Gerald Bruce** joined the Kahuku Hospital as assistant plantation physician. He is a graduate of the St. Louis University School of Medicine and interned at Mt. Carmel Hospital in Detroit. Dr. Bruce is married and has a son.

The blue waters of the South Pacific have temporarily lured **Drs. Alvin Majoska** and **Robert Hitchen.** Dr. Majoska left Honolulu on the yacht "Chiriqui" in the race to Tahiti. From Tahiti he will leave for Mangareva, Pitcairn, Easter, Galapagos, and Balboa. Dr. Hitchen gave up his office in Honolulu and will roam the South Seas for the next few months. Following that he ultimately plans to return to his native land of Canada.

St. Francis Hospital announces the appointment of **Dr. Lionel McHenry Mapp** as resident in obstetrics and gynecology. Dr. Mapp, a native of Trinidad, British West Indies, obtained his medical education at McGill University, Montreal. Prior to coming to Honolulu, he was plantation physician in Trinidad and also served as part-time government physician.

Kapiolani Hospital added two new resident physicians to its staff. They are **Dr. Nathan Shklov** and **Dr. Teruko Goto.**

Dr. Shklov received his training at the University of Manitoba, Winnipeg, and his M.D. from Queen's University School of Medicine, Kingston, Ontario, and interned at Vancouver General Hospital, Vancouver. Dr. Goto was born in Okayama-ken. She received her medical degree at Toho Medical college and completed one year internship at St. Mary's Hospital, Kansas City, Mo., and one year residency at Glockner-Penrose Hospital, Colorado Springs, Colorado.

**Dr. L. T. Chun** and **Dr. Duke Cho Choy** were recently elected members of the American Academy of Pediatrics.

Our congratulations for recent certification by various Specialty Boards go to: **Dr. Y. T. Wong** (American Board of Psychiatry), **Dr. Dorothy Natsui** (American Board of Psychiatry), and **Dr. Kameichi Takenaka** (American Board of Pediatrics).

**Dr. G. B. Fiore** announces the opening of his offices at the Kaneohe Community Center.

Congratulations go to **Dr. and Mrs. D. Paskowitz** who are the proud parents of a girl, Deborah, their first child; also to **Dr. and Mrs. Robert M. Browne** on the birth of their first child, a boy, Kevin Keolani, on June 16; to **Dr. and Mrs. Frederick Gilbert** who announce the arrival of their fifth child on June 25, a girl, Lisa; and to **Dr. and Mrs. Albert K. T. Ho** on the birth of their third child, Lawrence, on July 21.

**Col. Joseph McDonough** arrived in Hawaii to assume the position of Senior Surgeon with the U. S. Army Air Force at Hickam. Dr. McDonough is a graduate of the University of Nebraska School of Medicine and interned at Piedmont Hospital, Atlanta, Georgia. Prior to coming to his new post, Dr. McDonough served

with the 5th Air Force in Australia, New Guinea and the Philippines and also as chief of the Medical Selection Division, Office of the Surgeon General. Dr. McDonough is married and has two children.

New doctors joining the staff of the Territorial Hospital at Kaneohe are **Dr. Milton H. Rodofsky** and **Dr. Roger H. Dennett.** Dr. Rodofsky came here from Boston, where he had been in the private practice of psychiatry since 1948. He also was a faculty member of Tufts Medical School and consultant psychiatrist to the Boston State Hospital. Dr. Dennett is a graduate of New York University College of Medicine. After serving 37 months in the Army, he went into psychiatric training at the State Hospital for Mental Disease in Howard, Rhode Island and Yale University.

**Dr. Carl Mirikitani** announces the relocation of his offices in the Young Hotel Building.

**Dr. Pershing S. Lo** has been appointed assistant chief, Bureau of Mental Hygiene. Dr. Lo completed two years with the Air Force Medical Corps in the neuropsychiatric service at Mitchell Air Force Base Hospital, New York. He is an alumnus of Roosevelt High School, the University of Hawaii and the University of Michigan. He interned at Madison General Hospital, Wisconsin and was resident psychiatrist at Kings County Hospital, Brooklyn and Stony Ledge Hospital, Ossining, New York. He received additional training in psychoanalysis at Columbia University before entering the Air Force.

**Dr. and Mrs. F. D. Nance** have returned to Honolulu after a three month motor tour of Europe. While in France, Dr. Nance addressed the Lyons Pediatric Society.

**Lt. (j.g.) Edward C. Wo Lum** of the Naval Reserve was recalled to active duty on July 31. **Capt. Richard Noda** volunteered for active service and was sent to Fort Sam Houston in July.

**Dr. Hastings D. Walker** of Honolulu was re-elected Regent of the American College of Chest Physicians at the 1953 meeting of the College. **Dr. William F. Leslie** of Hilo was re-elected Governor for Hawaii.

On August 22 **Miss Florence Isoda** of the Medical Society office in Honolulu became **Mrs. Thomas M. Sueoka.** Her husband is a veteran of the 100th Infantry Battalion.

## Hawaii

**Dr. and Mrs. Hoei Higa** of Hilo welcomed their first son, Talmar, on June 24, 1953. Talmar weighed 7½ pounds and is their second child.

**Mrs. Edwin Willett** and her four children left for Bethesda, Maryland, on June 1, 1953, where they visited Mrs. Willett's parents. They returned to Laupahoehoe the first of September.

**Dr. George D. Oakley,** 1951 graduate of George Washington University Medical School, who interned at The Queen's Hospital in 1952, is the assistant physician to Dr. Edwin Willett at the Laupahoehoe Sugar Company. Mrs. Oakley is the former Miss Patricia Weatherbee and they have a year old son, David.

**Dr. Edwin Willett,** head physician at the Laupahoehoe Sugar Company, has been appointed physician of the Honokaa Sugar Company effective November 1, 1953. He will succeed **Dr. Clarence Carter.**

**Dr. Robert Kaufmann,** physician at the Hawaiian Agricultural Company, spent the week of July 27 in Honolulu with his parents, Mr. and Mrs. John Kaufmann of Decatur, Illinois. Mr. and Mrs. Kaufmann are planning to spend a month at Pahala with Dr. and Mrs. Kaufmann and their children before returning to Illinois.

**Dr. and Mrs. Nicholas Steuermann** of Olaa spent their three weeks vacation on Kauai in August.

**Dr. Greenlief H. Lambert,** radiologist at the Hilo Memorial Hospital, left for Los Angeles on July 23, 1953, where he will enter private practice.

## Kauai

**Lt. Keith F. O. Kuhlman,** of the 115th Medical Battalion now serving in Korea, received the Bronze Star for meritorious service. He was decorated by General Dunn, Commander of the 40th Division.

**Dr. Sam Wallis** is on a trip to the mainland.

**Dr. B. Strongman** is now the resident physician at the G. N. Wilcox Hospital. **Dr. R. Boudreau,** the former resident physician, returned to Canada.

The Advisory Committee to the Board of Maternal and Child Health held its first meeting on Kauai on July 17, 1953.

## Maui

**Dr. K. Izumi** was reappointed a member of the University of Hawaii Board of Regents.

**Dr. Al Burden** returned from the Mainland after a trek to the East which took him to the Kiwanis Convention.

**Dr. James Fleming** has returned to Maui after finishing an extended course in Hospital Management at the University of Chicago.

**Dr. S. Ohata** was oppointed by Governor King as a member of the Advisory Board of the Territorial Hospital and Institutions. He is also on the Maui County Board for the care of Medical Indigents.

**Dr. Ed Tompkins** is planning to leave for the Northwest for an extended vacation. Expects to do a lot of shooting among the jungle wilds of Oregon.


### Leprologist Wanted

Medical Director, Kalaupapa Settlement, Molokai. Salary $8800 to $9800 with perquisites. Training and experience required: (1) Four years of experience as a physician, of which two years shall have involved treatment of Hansen's disease patients; and graduation from a medical school of recognized standing, including or supplemented by one year of internship in a recognized general hospital; or (2) any equivalent combination of experience and training. In any case the doctor must be licensed to practice medicine in the Territory of Hawaii. Address the President, Board of Health, Box 3378, Honolulu, Hawaii.


# NEWS

## Hawaii Diet Manual

The second edition of the Hawaii Dietetic Association's Diet Manual has just been published and is now available to doctors, dietitians and nurses. It is a complete revision of the first edition and incorporates the newer trends of diet therapy practices approved by the American Dietetic Association. It has also been reviewed and approved by the Hawaii Medical Association and the Honolulu County Medical Society.

The revision was completed by the members of the diet therapy committee which includes dietitians from many Honolulu hospitals and members of the staff of University of Hawaii.

Copies of the *Hawaii Diet Manual* may be obtained by contacting any one of the dietitians at all Honolulu hospitals. The cost per copy for all professional and

non-professional persons is $3.00. It is the belief of the Hawaii Dietetic Association that the use of the *Hawaii Diet Manual* will mean a more standard diet procedure for the hospitals and physicians of the Territory.

## American College of Chest Physicians

The 20th Annual Meeting of the American College of Chest Physicians will be held in San Francisco, California, June 17-20, 1954. Physicians interested in presenting scientific papers on any phase in the diagnosis and treatment of heart and lung disease should send a 100 word abstract, not later than January 1, 1954, to Dr. Edgar Mayer, Chairman of the Committee on Scientific Program, 850 Fifth Avenue, New York 21, New York.

The Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the respective state chapters of the college as well as the staffs and faculties of the local hospitals and medical schools, will sponsor the Sixth Annual Postgraduate Course on Diseases of the Chest to be held at the Hotel New Yorker, New York City, November 2-6, 1953. Tuition is $75.

Further information may be secured by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

## North Carolina Centennial

The Medical Society of the State of North Carolina will conduct its 100th Annual Session at Pinehurst, North Carolina, May 3, 4 and 5, 1954.

## Second International Congress of Cardiology

The Second International Congress of Cardiology will be held in Washington, D. C., September 12-15, 1954. It will be immediately followed by the Annual Scientific Sessions of the American Heart Association, September 16-18, 1954.

## Urology Award

The American Urological Association offers an annual award of $1000.00 (first prize of $500.00, second prize $300.00 and third prize $200.00) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than ten years, and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Waldorf-Astoria, New York City, May 31-June 3, 1954.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before February 1, 1954.

## Fellowships for Research in Arthritis

The Arthritis and Rheumatism Foundation is offering the following research fellowships in the basic sciences related to arthritis:

1. Predoctoral fellowships ranging from $1,500 to $3,000 per annum, depending on the family responsibilities of the fellow, tenable for 1 year with prospect of renewal.
2. Postdoctoral fellowships ranging from $3,000 to $6,000 per annum, depending on family responsibilities, tenable for 1 year with prospect of renewal.
3. Senior fellowships for experienced investigation will carry an award of $6,000 to $7,500 per annum and are tenable for 5 years.

The deadline for applications is November 1, 1953. Applications will be reviewed and awards made by February 15, 1954.

For information and application forms address the medical director, The Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, N. Y.

## Dermatology Essay Contest

The American Dermatological Association is again offering a series of prizes for the best essays submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate investigators to original work in these fields. Cash prizes will be awarded as follows: Five hundred dollars, three hundred dollars and two hundred dollars for first, second and third place, respectively.

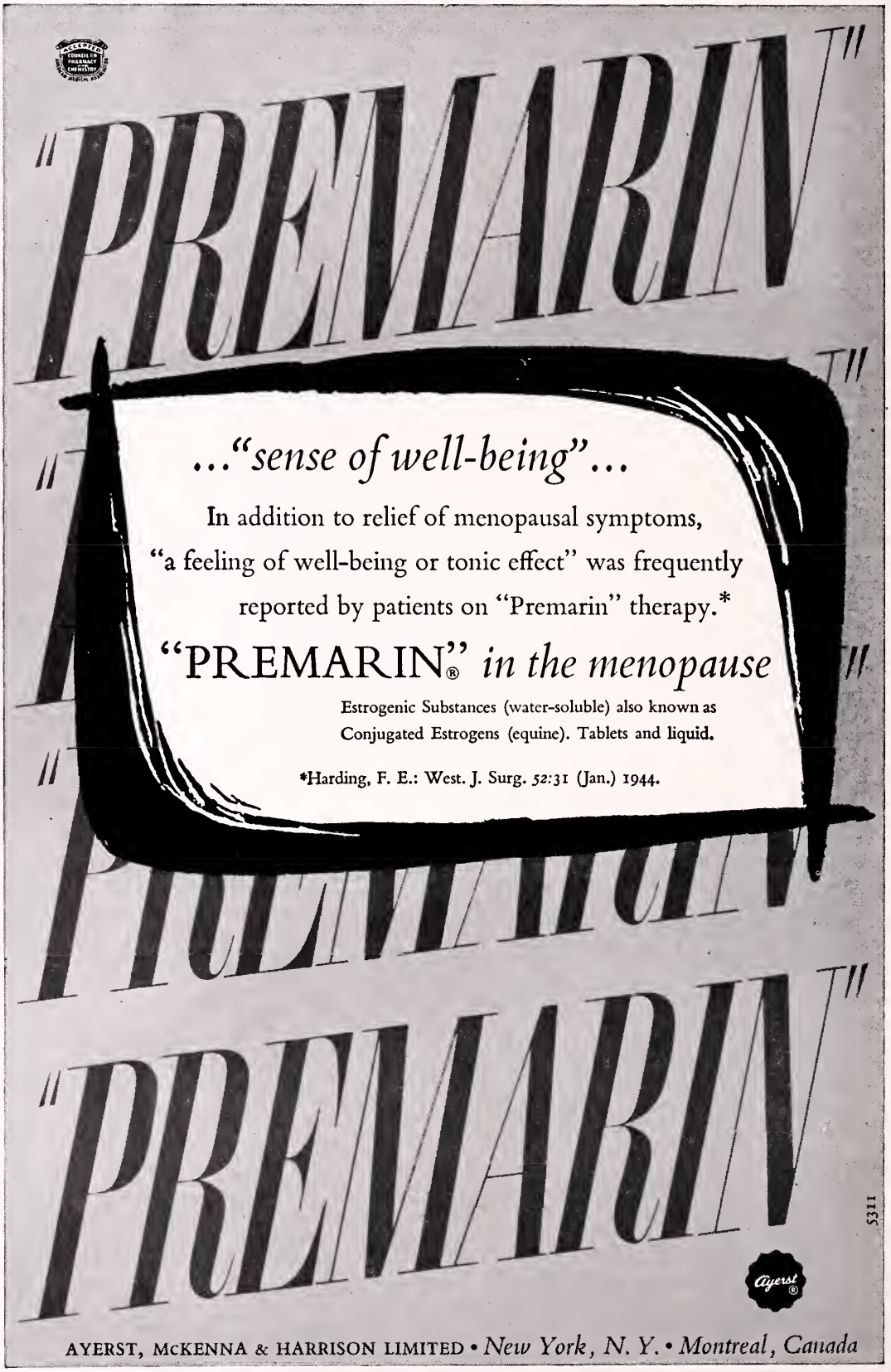
Manuscripts typed in English with double spacing and ample margins as for publication, together with illustrations, charts, and tables, all of which must be in triplicate, are to be submitted *not later than December 1, 1953.* The manuscripts should be sent to Dr. J. Lamar Callaway, Secretary, American Dermatological Association, Duke Hospital, Durham, North Carolina. Those which are incomplete in any of the above respects will not be considered.

## South Dakota Licenses

The South Dakota Board of Medical Examiners has announced the passage of legislation creating an annual registration fee for licensees in that state in the amount of $2.00. The registration takes effect January 1, 1954. If you are licensed in South Dakota and wish to maintain that license by payment of the registration fee, please contact the South Dakota Board of Medical Examiners, 300 First National Bank Building, Sioux Falls, South Dakota.

## National Gastroenterological Association

The National Gastroenterological Association will hold its Eighteenth Annual Convention and Scientific Sessions at The Biltmore Hotel in Los Angeles on October 12, 13, 14, 1953.


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# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAM, *Executive Secretary,* Honolulu

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## PRESIDENT'S MESSAGE

*"Who shall find a valiant woman? Far and from the uttermost coasts is the price of her. The heart of her husband trusteth in her, and he shall have no need of spoils. She will render him good and not evil, all the days of her life. She hath sought wool and flax, and hath wrought by the counsel of her hands. She is like the merchant's ship, she bringeth her bread from afar. And she hath risen in the night, and given a prey to her household, and victuals to her maidens. She hath considered a field, and bought it: with the fruit of her hand she hath planted a vineyard. He hath girded her loins with strength, and hath strengthened her arm. She hath tasted and seen that her traffic is good: her lamp shall not be put out in the night. She hath put out her hand to strong things, and her fingers have taken hold of the spindle. She hath opened her hand to the needy, and stretched out her hands to the poor. She shall not fear for her house in the cold of snow; for all her domestics are clothed with double garments. She hath made for herself clothing of tapestry: fine linen and purple is her covering. Her husband is honorable in the gates, when he sitteth among the senators of the land. She made fine linen and sold it, and delivered a girdle to the Chanaanite. Strength and beauty are her clothing, and she shall laugh in the latter day. She hath opened her mouth to wisdom and the law of clemency is on her tongue. She hath looked well to the paths of her house, and hath not eaten her bread idle. Her children rose up, and called her blessed: her husband, and he praised her. Many daughters have gathered together riches: thou hast surpassed them all. Favor is deceitful, and beauty is vain: the woman that feareth the Lord, she shall be praised. Give her of the fruit of her hands: and let her works praise her in the gates."*

This direct quotation from the Book of Proverbs in the Old Testament (Douay Version) is offered as a tribute to the Associate Members of our Association. Most of these fine nurses are engaged in the art of housekeeping. The housewife, the mother, is the valiant woman of our day. Usually unsung, unnoticed—Mrs. Housewife is the balancing influence in our society today.

ELIZABETH S. MCCALL, R.N.
*President*

## PATIENT EDUCATION

### A CASE STUDY

HELEN SANEISHI*

In tuberculosis, as well as in other diseases, the patient's willingness to help himself is very important, because he can get well only if he helps himself. The nurse and the doctor will be there to help him, but the patient must do his share. In order for the patient to realize this, he needs to have a general understanding of his condition. It is for this reason that patient education is stressed as much as it is on the Admitting floor.

Teaching the patient is the responsibility of the entire hospital team—from the doctor, the nurse, the social worker, the occupational therapist, the hospital aides, to every other person who comes in contact with the patient—but most of the responsi-

* Student Nurse, Leahi Hospital (affiliating from The Queen's Hospital).

bility falls on the shoulders of the nurse, who has the opportunity to spend more time with the patient.

When does this teaching begin? Immediately upon the patient's admission to the hospital, which, in this case, is Leahi. However, in order to teach effectively there must be good rapport between the patient and the nurse. A friendly greeting, and extension of a feeling that the patient was expected and is welcome to this place where he can best receive help, is a good start toward forming this rapport. This is how P. L., a 20 year old Filipino man, was greeted when he walked into the Admitting floor with his luggage on the seventh of January. P. L. had been followed as a contact of his mother, who died of tuberculosis, and was referred by the Tuberculosis Bureau of the Department of Health. (His diagnosis was later established as N.T.A. Pulmonary TB 2-B.)

P. L. was escorted into his room and given a general orientation to his room and the hospital set-up and routine to help him feel at home in this entirely new environment. While helping him get his things settled into his room, he was informed about his disease, tuberculosis, not in medical terms, but in simple lay language which could be understood by any ordinary person. He was told that tuberculosis is not hereditary, but that each person who has this disease acquired it from another person.

With this in mind, he was taught the celluwipe technique, or the covering of his nose and mouth with a piece of tissue paper, or celluwipe, whenever conversing with another person or whenever he coughs or sneezes. He was told to carry celluwipes wherever he went, in order to protect his family and friends, the nurse, doctor, and other hospital personnel. He was instructed to use the paper bag pinned to his bed to dispose of the used celluwipes and not to swallow the germ laden sputum, but to expectorate it into the sputum cup provided, which would later be destroyed by burning.

P. L. carried out his celluwipe technique fairly well. He was conscious of the technique most of the time, although sometimes he forgot and had to be reminded.

P. L. previously had had the symptoms of cough, night sweats, weight loss of ten pounds; shortness of breath, especially when climbing stairs; anorexia; streaked sputum; and fatigue, especially after work; however, upon admission he stated he felt fine. He was then informed that a person may have tuberculosis without showing any symptoms of illness and that the earlier his tuberculosis is discovered and treated, the sooner he will recover. He was told that the main treatment for tuberculosis is rest, both mentally and physically. The specific rest hour periods were mentioned to him and the National Tuberculosis Association pamphlet, "Rest to beat TB" was given to him to help him understand the importance of proper rest. It was explained to P. L. that activities like work and play and worrying over emotional problems increase the oxygen requirement of the body and in order to get this oxygen, the lungs need to work harder. This prevents or delays healing of injured or diseased lung tissue. The principle of rest to heal injury is the same for injury anywhere else in the body, he was told, and the example of a cut on the finger was given as an illustration.

In reply to his inquiring about the medicinal therapy of tuberculosis, P. L. was told that there are medicines given to tuberculosis patients but that the primary therapy is bedrest. Medicines will help but they alone will not get the patient well, so it is mostly up to him to see that he gets plenty of rest.

The importance of a good, balanced diet was also emphasized to P. L. He was told that a balanced diet is very important to maintain health in the person without disease, so it is even more important in the person who is ill. He was encouraged to eat vegetables and fruits and lots of meat, fish, eggs, liver and milk and milk products. Protein was stressed because it is the body building and repairing element and in tuberculosis much of this element is lost in the expectoration of sputum. While talking about diet, P. L. was told that here in Leahi, visitors are discouraged from bringing all kinds of food from home because of the need of storage place, danger of spoiling and because eating all sorts of food in between and during meals would curb his appetite for the well-balanced hospital meals.

From time to time good hygiene habits like washing hands before meals and good oral hygiene were stressed and additional things of interest and National Tuberculosis Association pamphlets were given to P. L. All this teaching was not given in one massive dose but in intermittent periods and according to the patient's interest. P. L. was encouraged to ask the nurse or doctor if there were any questions in his mind. At first he was very quiet, asked no questions and seemed a little shy, but he soon became adjusted to his new environment. As a whole, I'd say that he was an ideal patient for he was cooperative and pleasant to talk with, ate well and observed rest hours and celluwipe technique well.

*This "plan for a patient's day" was written by practical nurse student, Mrs. Mary Pacheco, during the theoretical part of the practical nursing course before she had done any actual nursing.*

## MY DIABETIC PATIENT

Mr. William Maka called me two days before his wife came home from the hospital to see if I was available to care for her. Mele Maka, age 39, is a diabetic who had injured her great toe and had to have surgery performed on it. She was recovering quite well and was ready to be dismissed from the hospital.

I told Mr. Maka I was interested in the case and was glad to accept. I asked him if any arrangements were made for Mrs. Maka's homecoming. He said no, but was happy to accept any suggestions. I made an appointment to see him the next day at his home.

I arrived at 357 Lane Way about 8 o'clock and introduced myself to Mr. Maka, and later was introduced to their daughter "Mi Nei."

I was shown around the house and found that the house needed to be cleaned and the laundry done before Mrs. Maka came home. I also checked on the equipment needed for my nursing procedure but found practically nothing.

On asking Mr. Maka if he would mind using some of the lumber that was piled in the front of the house to make a tray, a little tray table, and a back rest, he said no, he would be glad to do so.

While he was busy making these little things, I busied myself with the house, laundry, and lunch. All this time I had Mi Nei help me; in this way I knew exactly where she was.

At lunch, I noticed that Mr. Maka seemed worried. While conversing with him, I found out that since Mrs. Maka's illness he had to stay home from work so very often because the babysitter didn't come to care for Mi Nei.

I suggested that if he wanted to go to work the next morning, I was more than glad to go and get Mrs. Maka. That suggestion brought a smile of relief.

At 2:00, after Mi Nei had had her bath and had taken her nap, Mr. Maka asked me to join him to visit his wife.

We started off for the hospital, Mr. Maka, Mi Nei, and I. We reached there at 3 o'clock. He went in. About 20 minutes later he was out, smiling brightly. He told me about speaking to his wife about going to work and she agreed it was a good idea.

I went in and was introduced to Mrs. Maka and started to talk to her. I assured her that Mi Nei was fine and was very anxious to see her. I liked Mrs. Maka, and I think by the time I left, Mrs. Maka liked me too.

In the meantime, Mr. Maka had gone down to the business office to take care of the bill and went back to the car to be with Mi Nei.

We left the hospital at 4 o'clock and reached home at 4:30 with some groceries and some other equipment necessary for my nursing procedures.

About five, I left for home. At seven the next morning, I was back again and found Mr. Maka ready for work. He left at 7:15, happy, and I felt that he trusted me.

I gave Mi Nei her breakfast, and while she was eating I straightened the beds and picked up some hibiscus to brighten my patient's room.

At 10:00 I bathed Mi Nei and put her best dress on. I felt if she was dirty, it would only depress Mrs. Maka. At 10:40, Mi Nei and I reached the hospital. The little angel was very anxious to see her mother. I went in and helped Mrs. Maka into the car from the wheel chair.

About 11:45, we got home. I helped Mrs. Maka into the house with her crutches and made her comfortable in bed. I took her T.P.R. and registered it on the chart I had made. I didn't have to give her any insulin because her next injection would be the next day.

I left her to rest and went out to prepare her lunch, which I tried to make taste as delicious as it looked. I wanted my patient to enjoy her meal even if she had to eat food from a diet list.

As you know, diabetes is a condition of the body where the body cannot use the sugar for heat and energy nor store it in the body, so the sugar overflows into the urine. In this case, we have to use insulin to enable the body to use the sugar. A diabetic should not eat any other foods except those that are on her chart, as insulin is planned to take care of that diet.

I was ready to serve her lunch at 12:15. I fixed a little table in the bedroom for Mi Nei and me. We visited with Mrs. Maka and had a very enjoyable lunch.

Afterward, I prepared Mrs. Maka for her afternoon rest. I massaged her back, fluffed her pillows, and made sure she was comfortable.

I took Mi Nei into the kitchen to tidy it. Afterwards, I washed Mi Nei's face and hands, put her to bed, and went to check on Mrs. Maka. She was resting very comfortably. I took her T.P.R., chatted with her for about 15 minutes, then left her ready for a nap.

I went into the kitchen and started supper.

At 2:30, Mi Nei woke up. I played with her until 3:30, then I gave Mrs. Maka her P.M. care and changed her dressing. In a little while, I

bathed Mi Nei and got her ready to meet her Daddy.

At 4:30, Mr. Maka came home quite pleased because Mrs. Maka looked happy, little Mi Nei was clean, and supper was almost ready.

I left in a few minutes, making sure first that my patient was comfortable.

## ACTION OF YOUR BOARD OF DIRECTORS

June 12, 1953

*Heard* reports of committee chairmen and special representatives.

*Accepted* request from Medical Society that $75 be paid by nursing associations for use of mimeograph. Files are to be kept of all mimeograph work done for NATH, NADO, and the Board for the Licensing of Nurses and at the end of the year (June 1954) the $75 will be prorated according to amount of work done.

*Discussed* recommendations sent by Executive Secretary to Department of Institutions. These recommendations were made following a series of conferences which were requested by the professional and practical nurses at Territorial Hospital.

*Moved* to request financial assistance from ANA in consideration of the need for a full time executive secretary to further the economic security program.

*Moved* to take out a contract for typewriter upkeep service.

*Moved* to purchase a "line-a-time," a device to assist in copying. Is a time and sight saver for the secretary.

*Moved* to accept Industrial Nurse Section rules if accepted by the NATH Committee on By-Laws.

*Accepted* names submitted by Hawaii League for Nursing for replacements needed on the Board for the Licensing of Nurses and for the Commission on Nursing Education and Nursing Service. Sent to Governor.

*Moved* that Nominations Committee submit names to ANA for service as ANA officers and in national committees. This was requested by ANA.

*Submitted* names to Department of Health for selection of one to serve on their Advisory Committee on Hansen's Disease.

*Appointed* Mrs. Lila Chang, Hilo Memorial Hospital, as Hawaii representative on the NATH Practical Nurse Committee.

*Agreed* that economic security pamphlet be sent to membership and that the economic security program be discussed at the convention in section meetings and at the House of Delegates.

*Moved* that NATH discontinue the $1 per member, which has been paid to the Nursing Service Bureau, since it is now in good financial condition; but that this $1 be retained in NATH's treasury.

## SPECIAL BOARD MEETING

July 8, 1953

A special meeting was called to discuss the Executive Secretary's report and recommendations sent to the Department of Institutions regarding Territorial Hospital. This report was released to the newspapers by the head of the Department of Institutions. The following representatives were invited to attend:

Dr. Charles H. Silva, Director of Department of Institutions (He sent his assistant, Mr. John Bergen.)
Miss Dorothy Benson, Director of Nurses, Territorial Hospital
Miss Loretta Schuler, Chairman, NATH Committee on Public Information
Sister Jolenta, Board for the Licensing of Nurses
Miss Virginia Jones, Commission on Nursing Education and Nursing Service
Miss Alison MacBride, President, Hawaii League for Nursing

The Board, upon the invitation of Miss Benson and Mr. John Bergen, decided to ask the cooperation of the Hawaii League for Nursing and the Commission on Nursing Education and Nursing Service in making a study of the nursing services in Territorial Hospital.

## ANNUAL REPORT
## COMMITTEE ON LEGISLATION

Your committee had six meetings before and during the meeting of the legislature in 1953. Before the legislative session we had a dinner meeting with Mrs. DuPonte, Chairman of the Health Committee of the House of Representatives and with Mr. Joe Itagaki, Chairman of the Health Committee of the Senate. At these meetings we had prepared a summary of our legislative program as approved by our membership, and asked their advice and assistance for this program. The Oahu District Association invited us to join them in a meeting with Representative King at his invitation to discuss his interest in our needs.

Our legislative program was presented to the Oahu Health Council by your chairman. Their Legislative Committee approved of the University School of Nursing and enlargement of the Practical Nurse School, but disapproved of the Commission on Nursing Education and Nursing Service and the Scholarships for Graduate Nurses. At a later meeting they agreed to assist us to work for the Commission for another biennium. A mutually beneficial working relationship was maintained with the Hawaiian Government Employees' Association. Copies of all minutes of our meetings and of all bills presented for nursing were sent to all district associations. As the need grew, the Oahu District Association Committee on Legislation met and worked with your committee. They were available for attending meetings of committees and sessions of the legislature when our bills came up for hearing and voting.

Nursing was represented at all meetings of the Senate Ways and Means Committee and the House and Senate Health Committees. This meant that someone was at the legislature every day and many evenings.

The Commission on Nursing Education and Nursing Service was established for another biennium; and the scholarship bill for nurses became

Act 277 when it was signed by the Governor. This act appropriates a sum of fifteen thousand dollars to be used as scholarships for locally born graduate nurses. Nurses receiving the scholarship must agree to serve in the Territory in a teaching, supervising or administrative position in nursing. It will be administered by the Board for the Licensing of Nurses.

The University School of Nursing received the funds requested; but the enlarged quarters for the Practical Nurse School were lost in the budget cut! Requests for funds for additional personnel at Territorial Hospital were not granted.

Recommendations:

1. That districts and sections invite elected members of the Senate and House to discuss proposed and planned legislation before the next legislature convenes.
2. That a constant program of education be maintained for NATH members on legislation and legislative processes.
3. That this committee be enlarged and interested associate members be added who are able to attend legislative sessions.
4. That the district associations strengthen their committees on legislation since the power in the legislature rests with the islands other than Oahu.
5. That some of the members be retained each year on this committee in order to guide the work as well as to carry out the second item above.
6. That, if possible, a policy be adopted by the House of Delegates regarding the support of health legislation for the guidance of the Legislative Committee.
7. That each member re-read articles 15, 16 and 17 of the ANA Code for Professional Nurses and activate this code by voting, broadening knowledge and interest in her community and developing more active public relations, keeping informed on the candidates running for office, voting intelligently for those who will appreciate our efforts in their behalf, and joining her precinct club.

MRS. MYRTLE SCHATTENBURG, *Chairman*

## REPORT ON PREMATURE INSTITUTE

Thirty nurses, fifteen of them from the neighbor islands, attended a two-week institute on prematurity held in Honolulu, April 6-17, 1953. Twenty physicians participated in the lectures and discussions, while St. Francis and Kapiolani hospitals made their premature units available for demonstrations.

A steering committee composed of hospital administrators, directors of hospital nursing, directors of schools of nursing, and physicians planned the institute. In addition to the one in Honolulu, shorter institutes were held on the islands of Hawaii, Kauai and Maui. Miss Ethel Tschida, supervisor of premature nurseries, and instructor in pediatrics, New York Hospital, Cornell University, acted as consultant and coordinator for all the sessions.

The World Health Organization defines a premature* infant as any infant born alive weighing 5½ pounds or less. Both in the Territory of Hawaii and on the mainland, prematurity is the leading cause of neonatal and infant death. In Hawaii in 1952, 78 of every 1,000 babies born alive were immature, and 10 of the 78 died in the neonatal period.

Many premature babies were born to families with low incomes. The cost of hospitalization of an infant weighing three pounds at birth was estimated at $1,200 to $1,500.

The importance of the nutrition of the mother was stressed, and a nutritionist gave constructive suggestions on how to help families adjust their food habits to include the essential nutrients.

Early and consistent medical supervision helps to prolong pregnancies. Conditions frequently associated with prematurity are multiple pregnancy, previous abortions, placenta previa, cardiac complications, nephritis, and poor nutritional status.

Supportive nursing care during labor and delivery, and administration of a minimum of analgesia and anesthesia increases the baby's chance for survival. Nurses were urged to consider the emotional and nutritional condition of the patient in labor, to limit manipulations (rectals, catheterizations, or enemas) to those ordered specifically by the physician, and to pay special attention to periodic checking of fetal heart tones.

Alert nurses, it was stated, could detect fetal distress early enough to allow the physician time for constructive action. Physicians agreed that fluctuating, very slow, or very rapid heart rates often indicate fetal distress. Pending the arrival of the physician, oxygen given to the mother might help the baby without harming the mother.

In emergency deliveries, obstetricians urged the nurses to allow the baby to proceed gradually through the birth canal, neither holding him back nor permitting him to descend abruptly. Nurses were advised not to cut the cord until all pulsations had ceased. A warm crib and blankets, suction equipment, and oxygen should be available for immediate use. The safest method of suction is gentle, allows for adequate clearance of the air passages, and may be continued by the nurses for long periods with the baby in the incubator and in oxygen. The importance of extreme gentleness in handling was stressed. Miss Tschida demonstrated suitable, safe methods of artificial respiration and stimulation. Proper equipment for transporting the baby from delivery room to nursery was shown.

Nurses expressed a need for written guides in emergency deliveries and in emergency care of

* In this report premature and immature are used interchangeably.

| PHYSICAL HANDICAP | PRINCIPLE | PROCEDURE—NURSING ACTIVITY |
|---|---|---|
| Inadequate temperature control | Provide environment simulating that in utero | Incubator carefully adjusted to baby's need |
| Poorly developed respiratory apparatus | Supply infant with adequate oxygen | Keep air passages suctioned free of mucus, provide oxygen, artificial respiration as indicated |
| Inadequately developed gastrointestinal tract | Provide nutrition in a form that can be assimilated | Avoid early feedings, give first feedings of water or glucose, guard against aspiration of regurgitated feedings. Do not give bottle or dropper feedings to the baby who cannot suck, cough, or swallow |
| Tissues delicate and thin. Bleeds easily. Skin glands non-functioning. | Avoid breaking tissues or pressure on vital centers | Keep in level position on either side except for short periods as necessary for excessive mucus. Handle with great gentleness. Skin cleansing only as necessary |
| Low energy reserve. Convulsion threshold low. | Avoid fatigue or undue pressure on vital centers | Carefully planned routines to include all necessary care at once. Avoid undue handling; choose suitable method of feeding to avoid exhaustion. Long rest periods |
| Low resistance to infection | Protect against exposure | Provide individual care. Observe rigid technique re hand washing, sterilizing equipment, rules for visitors and health of personnel<br>Teach parents how to protect child, institute adequate medical followup and referral for home supervision |
| Susceptibility to anemia | Protect against blood loss and provide medical followup | Provide proper nutrition. Guard against blood loss through too early cutting of cord. Vitamin K frequently a standing order. Emphasize medical followup |

the premature infant. Such guides were developed by a committee of two obstetricians, pediatricians, and nurses.

"Complete individualization of every premature baby and planning his care to meet his needs" was the theme of all discussions on nursing care. Hand washing before and after handling the infant was stressed as an absolute necessity. A recent study of bacterial counts on nurses' hands after thorough scrubbing showed that new fingernail polish, cracked fingernails, long fingernails, and rings with stones or elaborate designs increased bacterial counts. Masks must be properly worn and frequently changed to be of value. Nurses regularly assigned to premature nurseries probably do not need them, but all other persons should wear masks, caps, and gowns when entering the nursery.

The consultant reviewed the essentials of a good incubator and demonstrated the Gordon Armstrong and the Isolette incubators. Desirable features to consider in new incubators were:

A good, safe, heat-regulating mechanism controlled by a thermostat
Good visibility and comfortable access to the infant
Humidity control
Oxygen conservation properties

The teamwork of an interested, informed physician and nurse is the important factor in conservation of premature life; the incubator is a helpful tool.

The immature baby has certain basic physical handicaps around which nurses can develop the principles of adequate care as outlined above.

Each nurse attending the institute received educational materials suitable for distribution to parents. Since the premature baby catches up with his siblings in growth and development by the third to the fifth year, parents should consider him as a normal infant. Overprotection by parents

may retard the social development of the immature infant.

The active participation of physicians and nurses and the wide experience and knowledge of Miss Tschida, the nursing consultant, contributed to the success of the institute.

THE PREMATURE INSTITUTE
PLANNING COMMITTEE

## HAWAII STUDENT NURSES LEAD IN NATIONAL EXAMINATIONS AGAIN

Hawaii averaged higher scores in medical and obstetrical nursing than any of the forty-five States and the Canadian Provinces of Alberta and British Columbia included in the 1952 report of State Board Test Pool Examinations for professional nurse licensure.

Graduates of Hawaii schools of nursing not only made the highest averages in these two subjects but they ranked well near the top in the other four examinations which included nursing of children, communicable disease nursing, surgical nursing, and psychiatric nursing. Their lowest rankings were in the fields of surgical nursing and nursing of children where they came in eleventh.

Hawaii can indeed be proud of the achievement of its young nurses. It is hoped that future graduates of Territorial schools of nursing will continue to maintain such an enviable record.

SISTER M. JOLENTA, R.N., *Chairman*
Board for the Licensing of Nurses

## ONE MORE REPORT FROM THE SAN FRANCISCO WORKSHOP ON SECTION ORGANIZATION

The workshop which was held in San Francisco was wonderful! Since it was my very first trip away from Honolulu, I found even the plane ride exciting and thrilling.

Meeting nurses from other parts of the United States and discussing various problems all very stimulating. I learned that the problems we have in Hawaii also confront the nurses on the mainland. Recruiting members into the Nurses' Association is one of the problems faced by all districts and all sections alike. I attended the workshop with the aim of finding a solution to this particular problem but I found that the other nurses also attended the workshop with the same idea!

Dues on the West coast range from about $30 to as high as $42 while in Hawaii the dues are only $22 a year to be a member of the Nurses' Association where we may participate in many activities and find unlimited opportunities.

After all, when we survey our problems and compare them with those of the other districts, we find that we are not in a very bad position.

LOUISA N. KIMURA
*Special Groups Section (Office Nursing)*

## REPORT OF THE NURSES' ASSOCIATION, COUNTY OF KAUAI

The Kauai Nurses' Association is pleased to report that our membership has increased a little this year to 52 active and 9 associate members—an increase of 4 active members. All the members are serving on committees and we are particularly happy about the active part our associate members take in our activities.

Our project of awarding two scholarships each year to Kauai girls entering schools of nursing has been continued. The scholarship committee has been in function for the past four years, and to date we have awarded eight scholarships. Only five girls applied this year as compared with twelve last year. Recipients of the scholarship this year were Josephine Basa of Waimea High School and Encarnation Gerardo of Kauai High School. Josephine will be entering The Queen's Hospital School of Nursing, and Encarnation St. Francis Hospital School of Nursing. Our first recipient of the scholarship will be graduating from St. Francis Hospital School of Nursing this summer, and we are looking forward to seeing her on Kauai and welcoming her into our association as a regular member. As you know, the association finances this project through an annual rummage and plant sale, and any contributions that are made by doctors and friends.

Preparations are being made now for the rummage sale to be held in August.

As usual, members of the association assisted, through the Red Cross, with National Guard immunizations and with the skin testing and immunization program in the three high schools.

There is now a well organized and active Practical Nurses' Association on Kauai. They have been assisted in their organization work by several members of the Nurses' Association and were invited as a group to attend one of our meetings. It is hoped that the relationship between the two groups will continue to be congenial and mutually helpful.

Whereas last year the programs at our meetings were planned around Civil Defense, this year they have presented a variety of interests. Two physicians have been speakers, but for the most part we have depended largely on our own membership for participation in the meetings. Meetings of this type are harder to plan and less predictable as to

quality, but we feel that our members have much to give and that the experience contributes to our own growth and professional development. Miss Adam visited us in March to conduct a discussion on legislation, and in April Mrs. Mabel McConnell led a discussion on nurse-patient community relationships. The December meeting was for Christmas fun; the July meeting was a hukilau for both fun and money raising.

With a large proportion of new officers and new committee chairmen taking part, we feel that our organization has been strengthened and is prepared to carry on a worthwhile organization program in the coming year.

MYRNA G. CAMPBELL, *President*

## ANNOUNCEMENT FOR PRIVATE DUTY NURSES

Early in September the Private Duty Section of the American Nurses' Association will send by direct mailing a two-part questionnaire to a ten per cent sample of the ANA Private Duty membership list.

The questionnaire is designed to help in defining functions, standards and qualifications for practice of private duty nursing. In Part I the nurses will be asked to indicate the responsibilities they assume for various nursing functions. From the questions in Part II, the section hopes to find out what private duty nurses think about their field of nursing, how they can better meet the needs of the public, and how they can obtain greater professional satisfaction in this field.

In order for the survey results to be truly representative, the section urges that each nurse who receives a questionnaire *fill it out and return it to ANA headquarters promptly*. Each reply makes an important contribution to an overall picture of the private duty nurse.

## NEWS FROM MAUI

A picnic supper was held by the Maui Nurses' Association at the Puunene Hospital nurses' beach cottage for the students entering schools of nursing this fall. Three will enter St. Francis School of Nursing in Honolulu; one will enter Queen's; one will go to St. Mary's College of Nursing in California; another to Mount St. Mary's College, St. Vincent's Hospital, California; another to Mary's Help Hospital School of Nursing, San Francisco; and still another to St. Mary's College of Nursing in San Francisco.

## KAUAI NEWS

Miss Florence Muraoka has been appointed Public Health Nurse for the Kapaa district, replacing Mrs. Grace Furugen who has been transferred to Lihue.

The Nurses' Association, County of Kauai, held its annual rummage sale on August 5 and 6, the proceeds of which go towards two scholarships awarded annually. The first scholarship student, Miss Euphemia Padilla, will be returning to Kauai in September.

Miss Dale Ebata, Miss Mary Lou Byers, and Miss Romayne Larsen left on August 1 for Chicago.

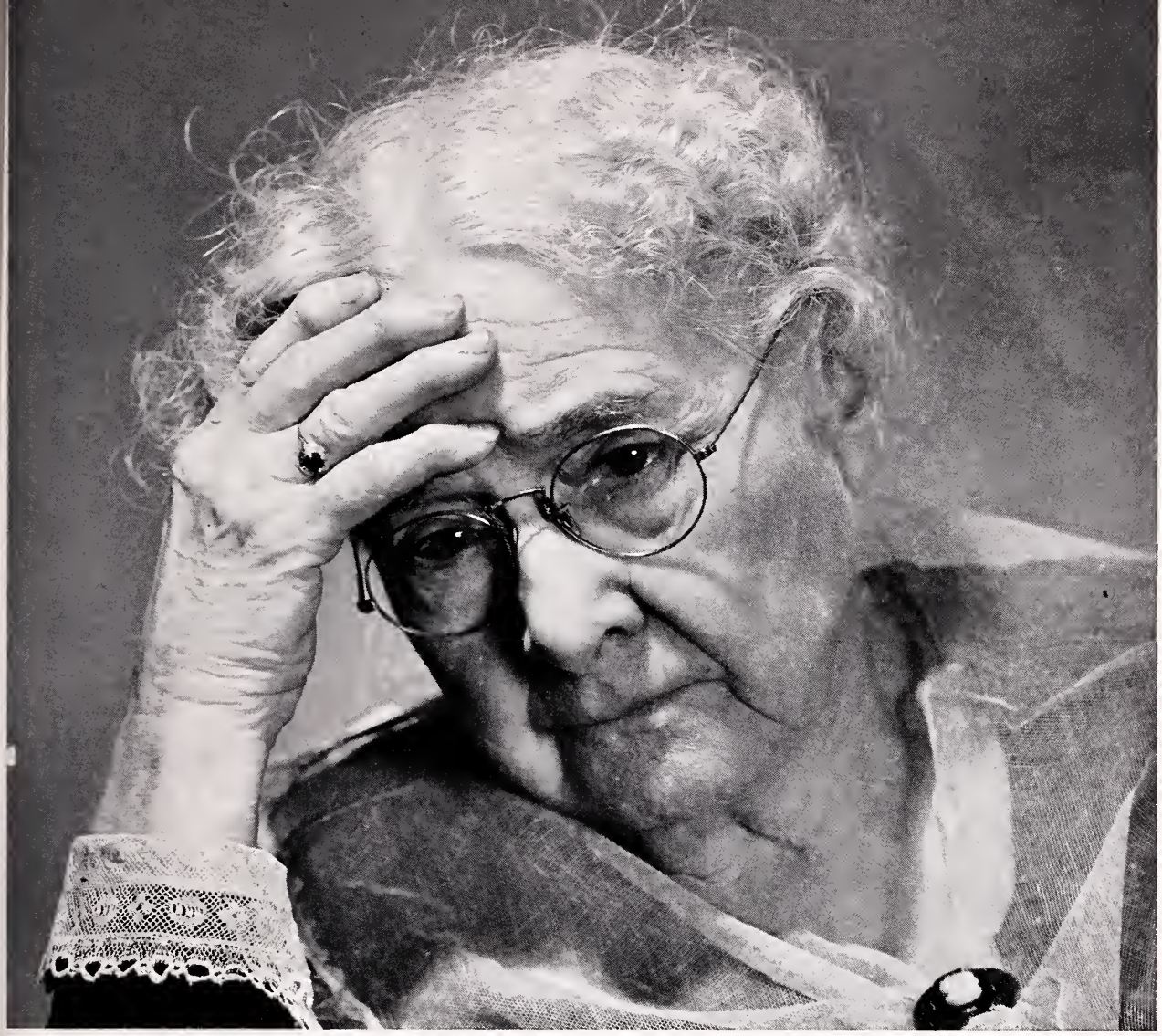
Miss Myrna Campbell, Miss Elizabeth Middleton, Mrs. Grace Furugen, Miss Josephine Cortezan, Miss Esther Nakamae, and Miss Martha Hiramoto were elected as delegates to the 1953 Nurses' Convention on Maui. Alternates include Mrs. Helen MacPherson, Miss Helen Hetrick, Miss Florence Muraoka and Miss Hilda Nemoto.

## NEW ANA UNIT

The Isthmian Nurses' Association of the Canal Zone is now the 53rd constituent unit of the American Nurses' Association.

This newest unit of the ANA is made up of about 100 nurses who live in the Canal Zone or environs. It was organized in 1951. It is made up chiefly of members of the military nurse corps, the rest are civilian nurses working in government hospitals and with the Point Four Program of the United States.

Other units besides the 48 states are the District of Columbia, Hawaii, Alaska, and Puerto Rico.



The inevitable restrictions of advancing years, the reduced activity and a lowered intake of bulk-producing foods all contribute to the high incidence of constipation in older persons.

# CONSTIPATION IN THE AGED

## Constipation is almost a universal complaint of geriatric patients

Frequently, too, the protracted use of cathartics has left the colon in an atonic state and it is no longer capable of effecting a normal evacuation.

Metamucil has long been recommended for the treatment of constipation in the elderly. A highly refined vegetable product which is free from irritants, Metamucil effects a natural mechanical stimulus in the colon which helps the dysfunctioning muscles to regain and maintain their normal tone.

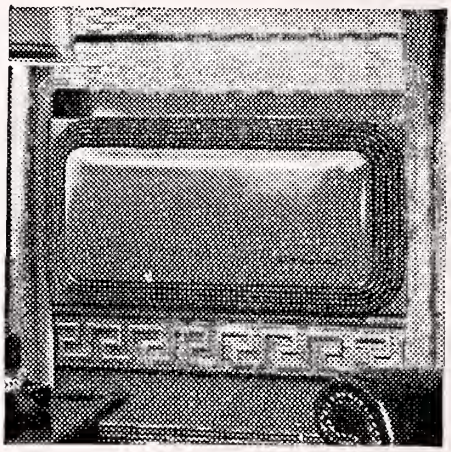
Metamucil may be safely prescribed for prolonged use without fear of dependence, intestinal irritations or allergic reactions.

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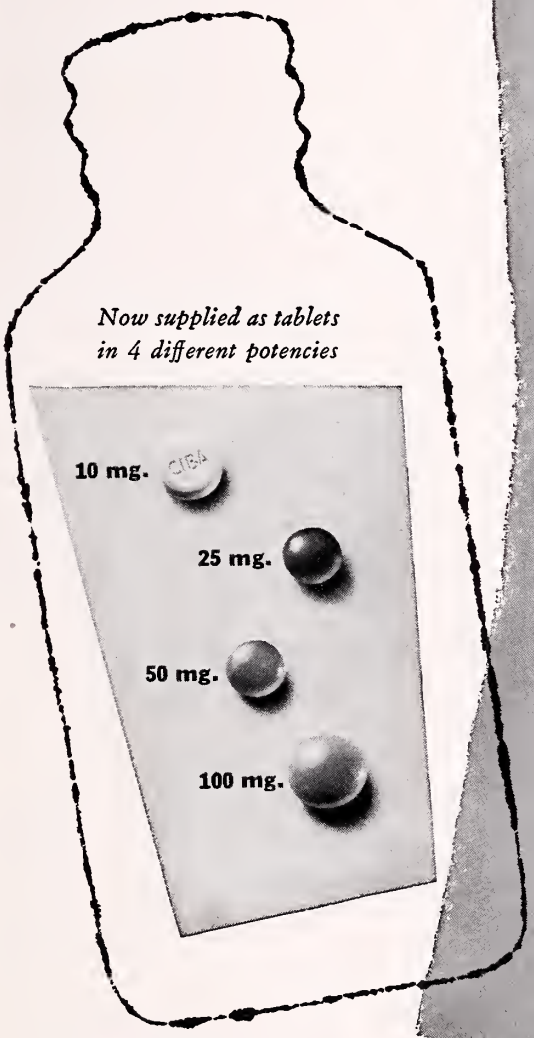
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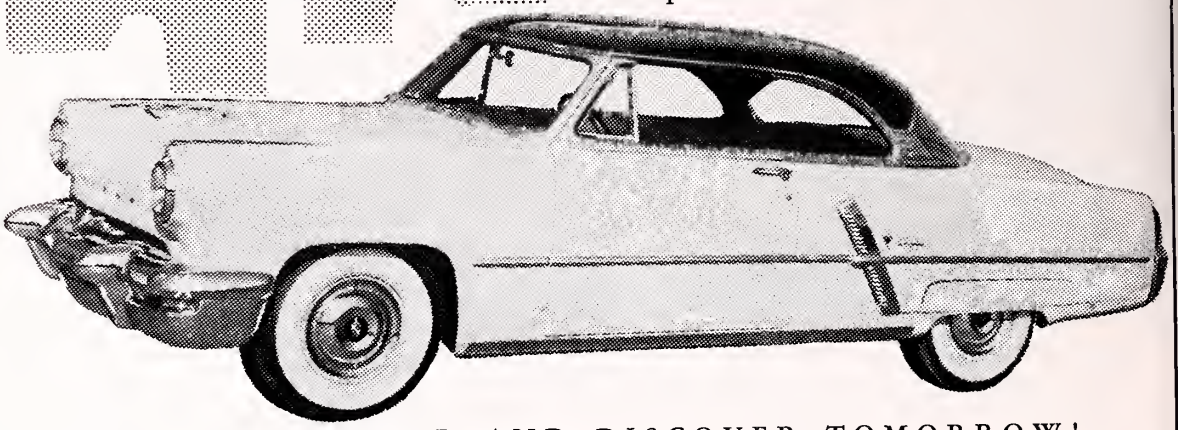
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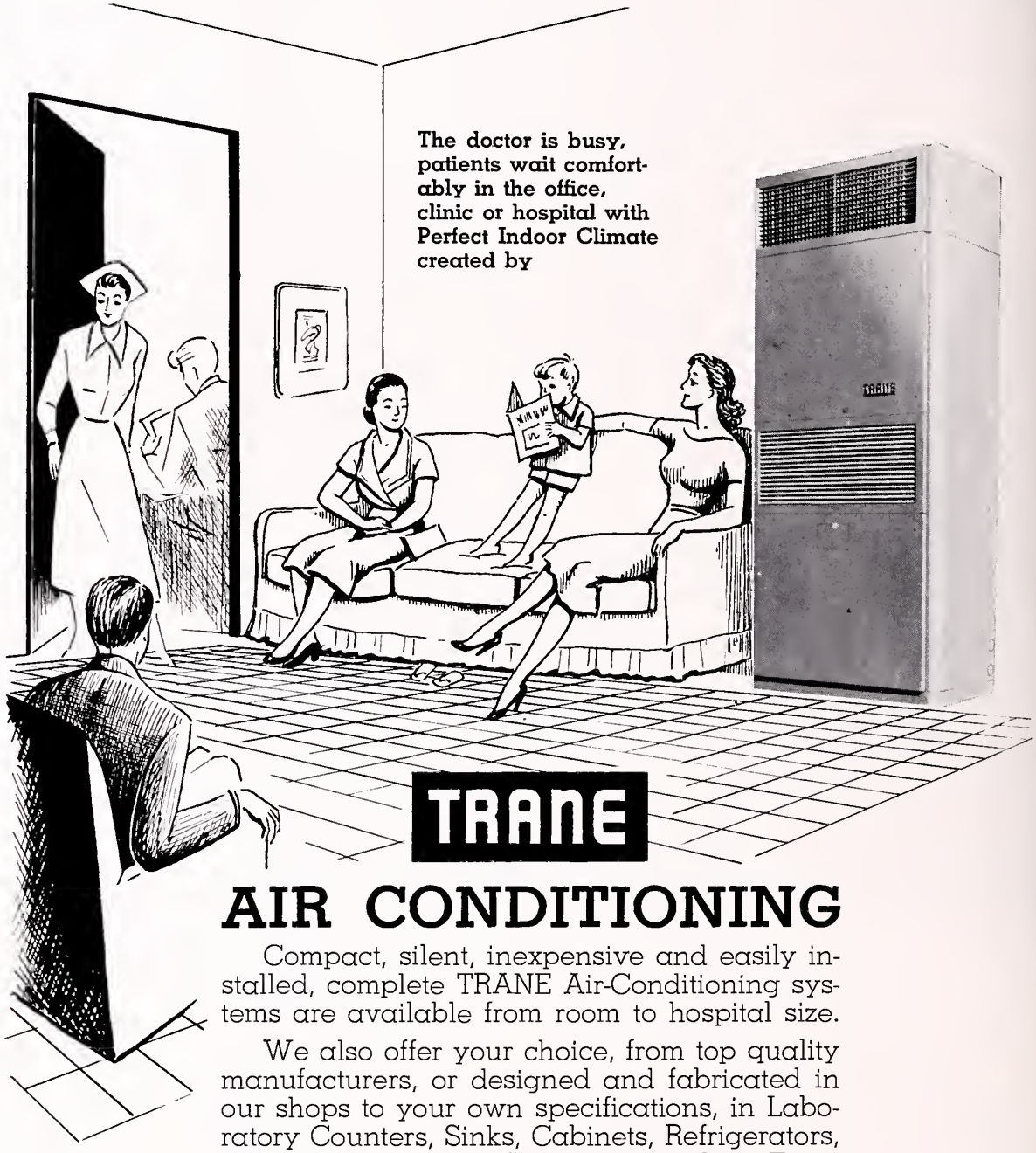
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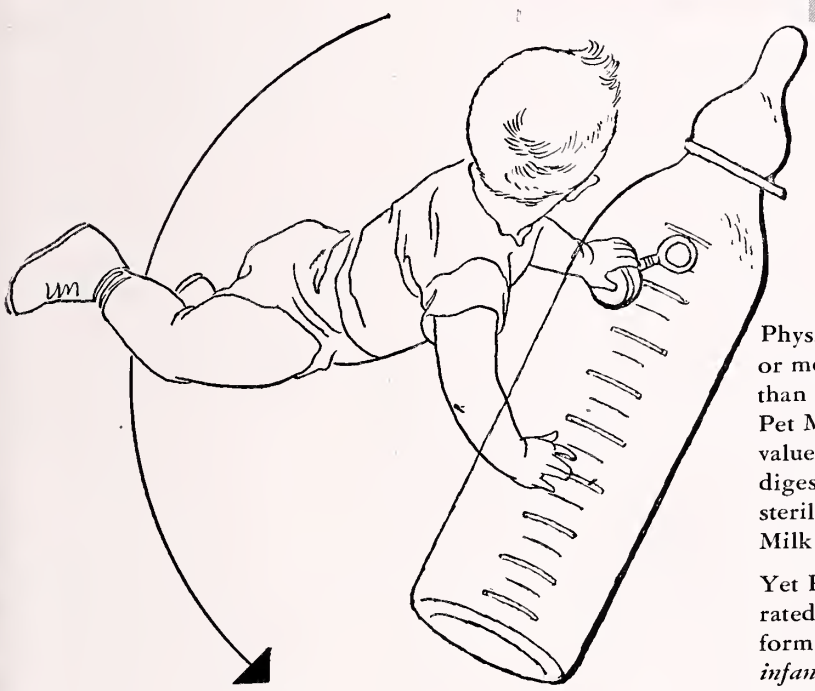
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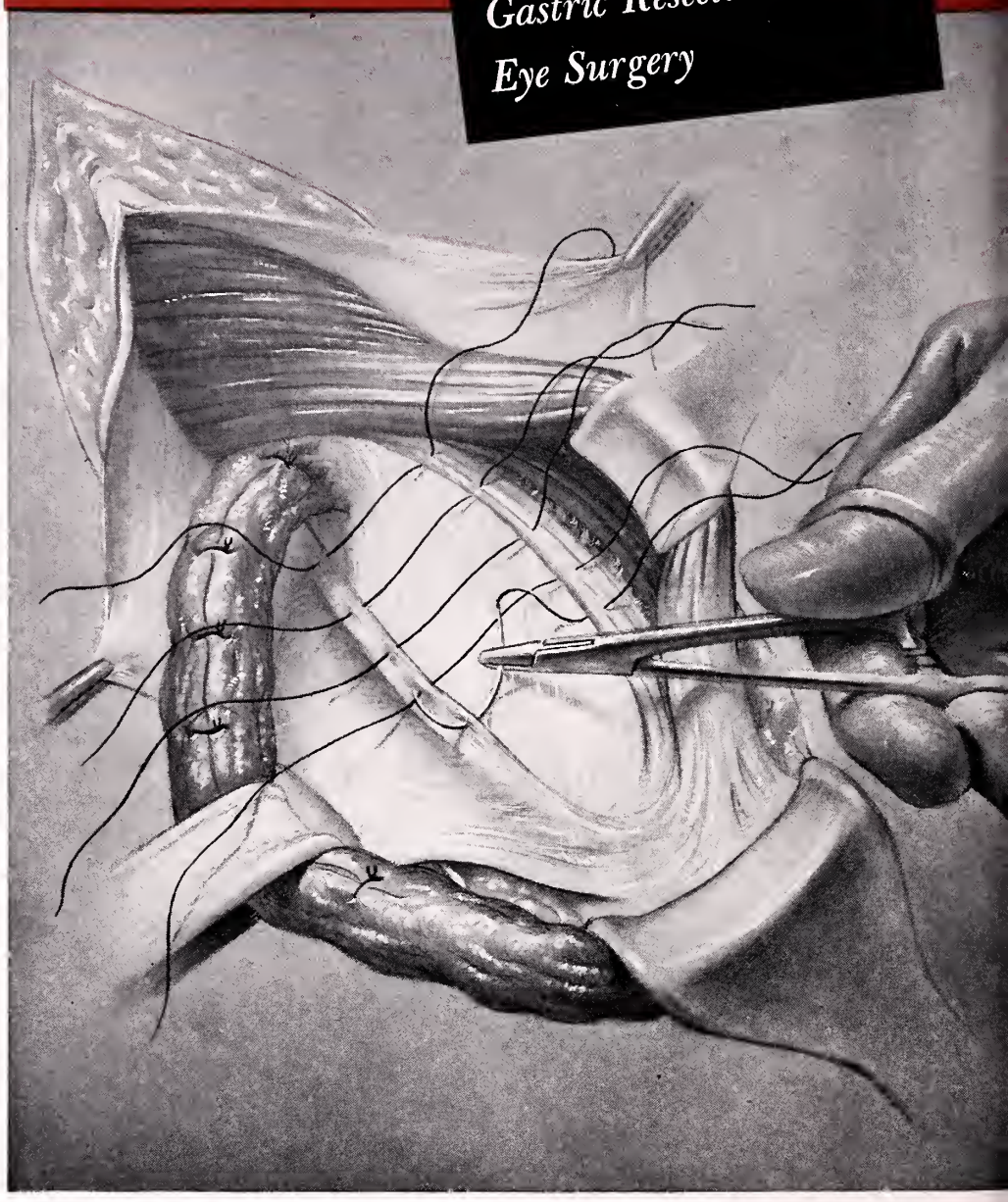



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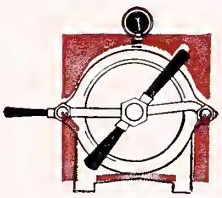
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## SURGICAL SILK

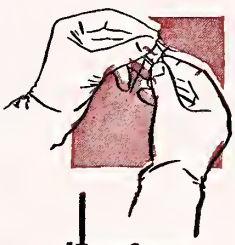
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AMERICAN MEDICAL ASSOCIATION

THE EDITORS of The Saturday Star-Bulletin are pleased to announce that Dr. Walter C. Alvarez is now writing a weekly health column exclusively for the Hawaiian Life magazine of the newspaper.

Dr. Alvarez, emeritus member, Division of Medicine, Mayo Clinic, and professor of medicine, Mayo Foundation, is well known to members of the medical profession in Hawaii.



DR. ALVAREZ

As a writer interpreting medical and technical data in lay language, Dr. Alvarez is recognized as the most articulate of contemporary authorities and has written many papers and books for the profession, as you are well aware.

In agreeing to write exclusively for The Saturday Star-Bulletin in Hawaii, Dr. Alvarez said that it would be his constant effort to provide Star-Bulletin readers with accurate, careful and wisely considered medical information, just as soon as that information reaches the point where it will be fair to tell the public.

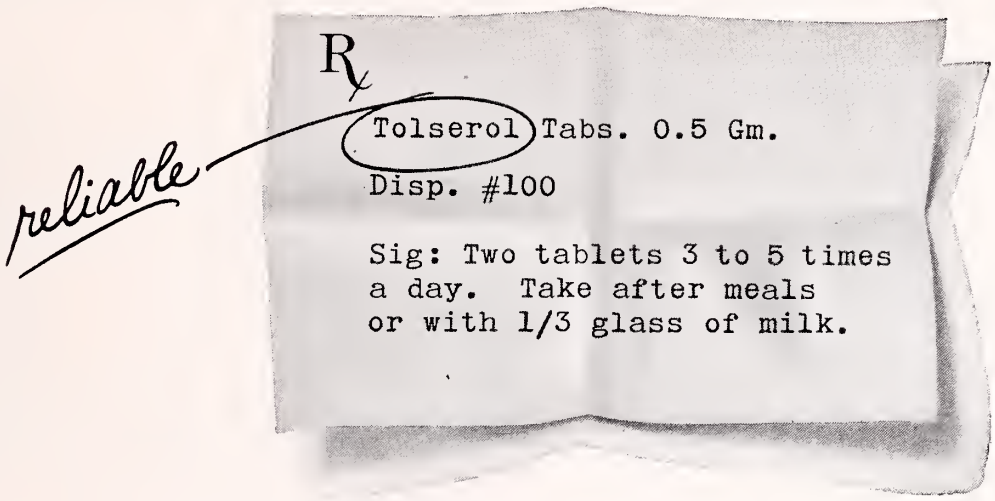
The Star-Bulletin is happy to present this public service feature to the people of Hawaii. It does so with the happy knowledge that Dr. Alvarez's articles will, among other advantages, promote a better understanding of the vital work of members of the medical profession here in Hawaii.

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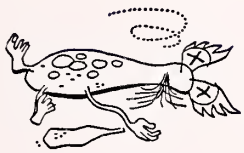
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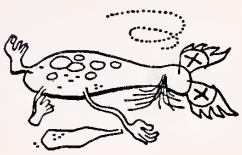
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because it does not materially alter normal intestinal flora; gastrointestinal disturbances rare; no serious side effects reported.



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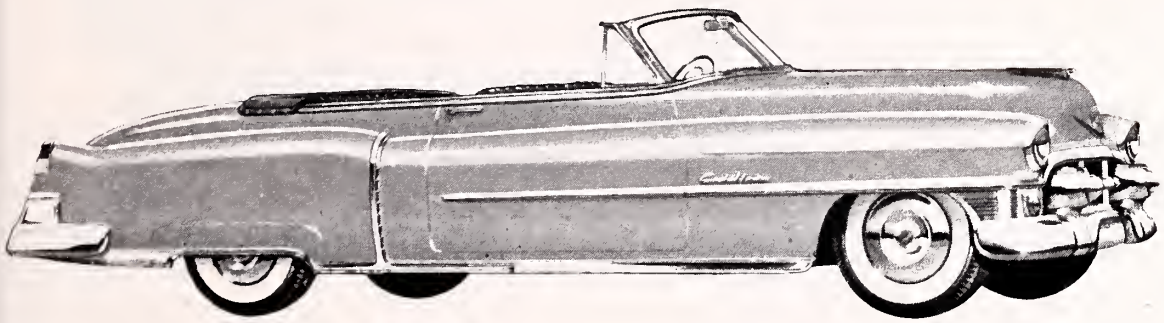
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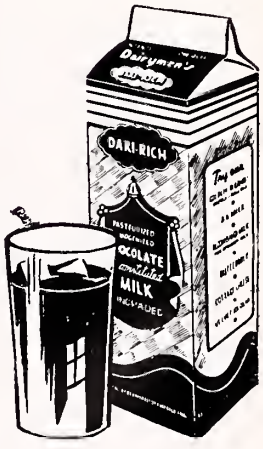
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We don't have to tell you the importance of fresh milk to growing children. Since time began, milk has been our first food and a necessary food all through life. Doctors and nutritionists constantly repeat the need for children to have at least a full quart of fresh milk daily. Won't you help them by reminding them too?

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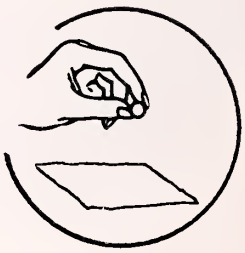
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are often found through simple, direct tests. Ames Diagnostic Tablet Tests supply the needed evidence with precision, simplicity and speed.

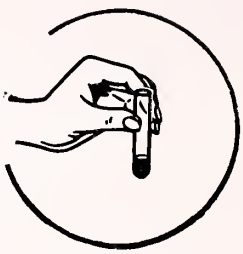
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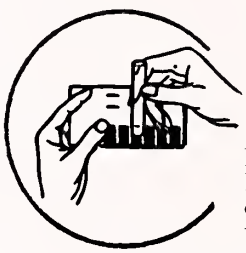
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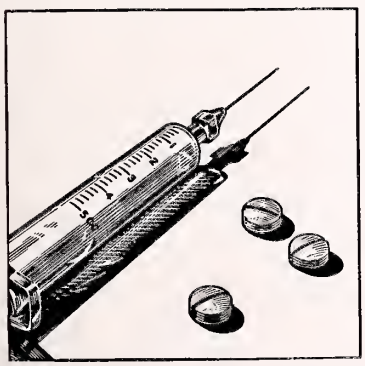
POTASSIUM

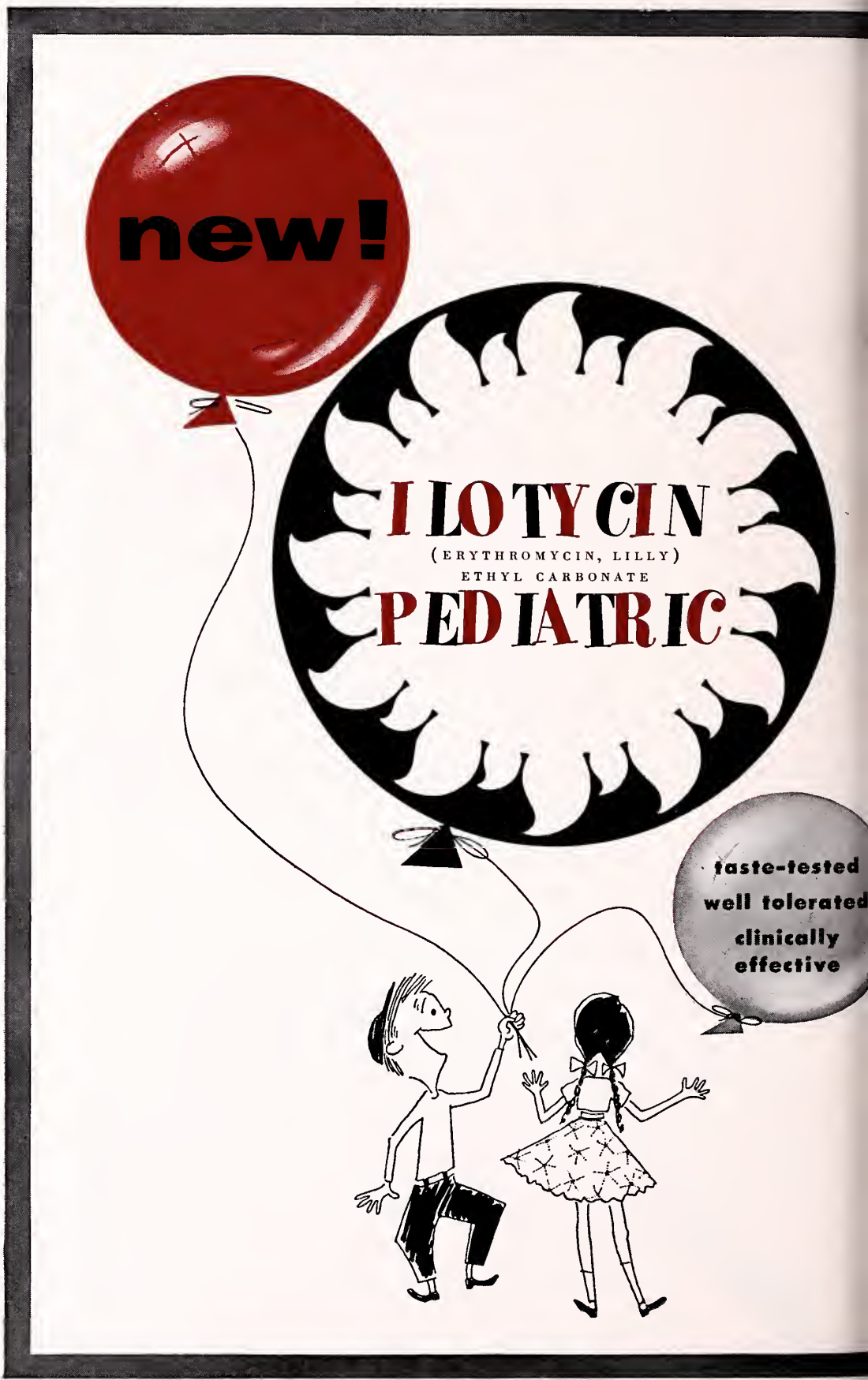
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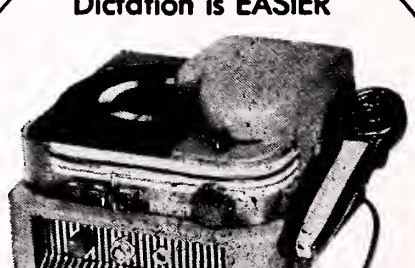
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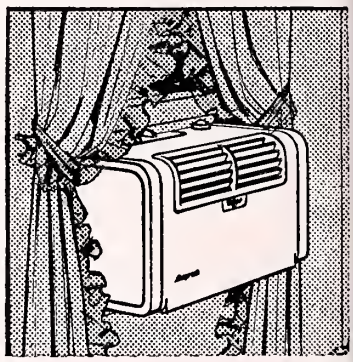
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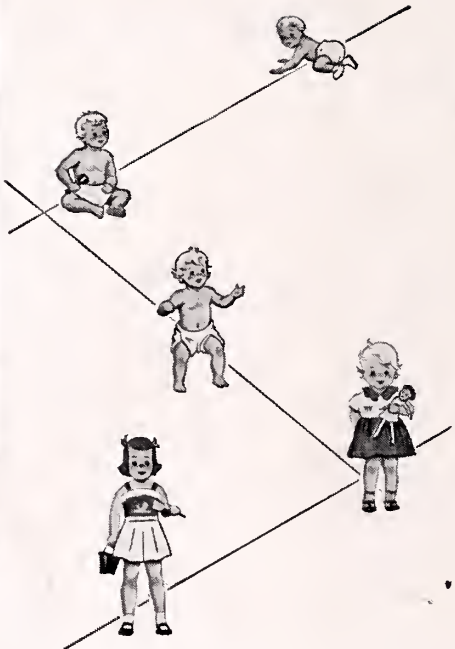
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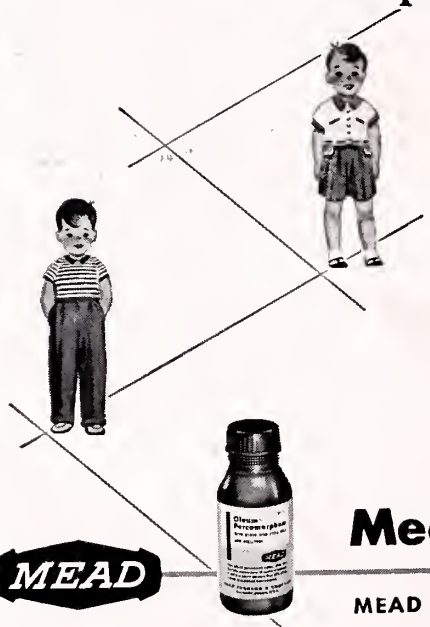
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By Oliver Kamm, T. B. Aldrich, I. W. Grote, L. W. Rowe and E. P. Bugbee

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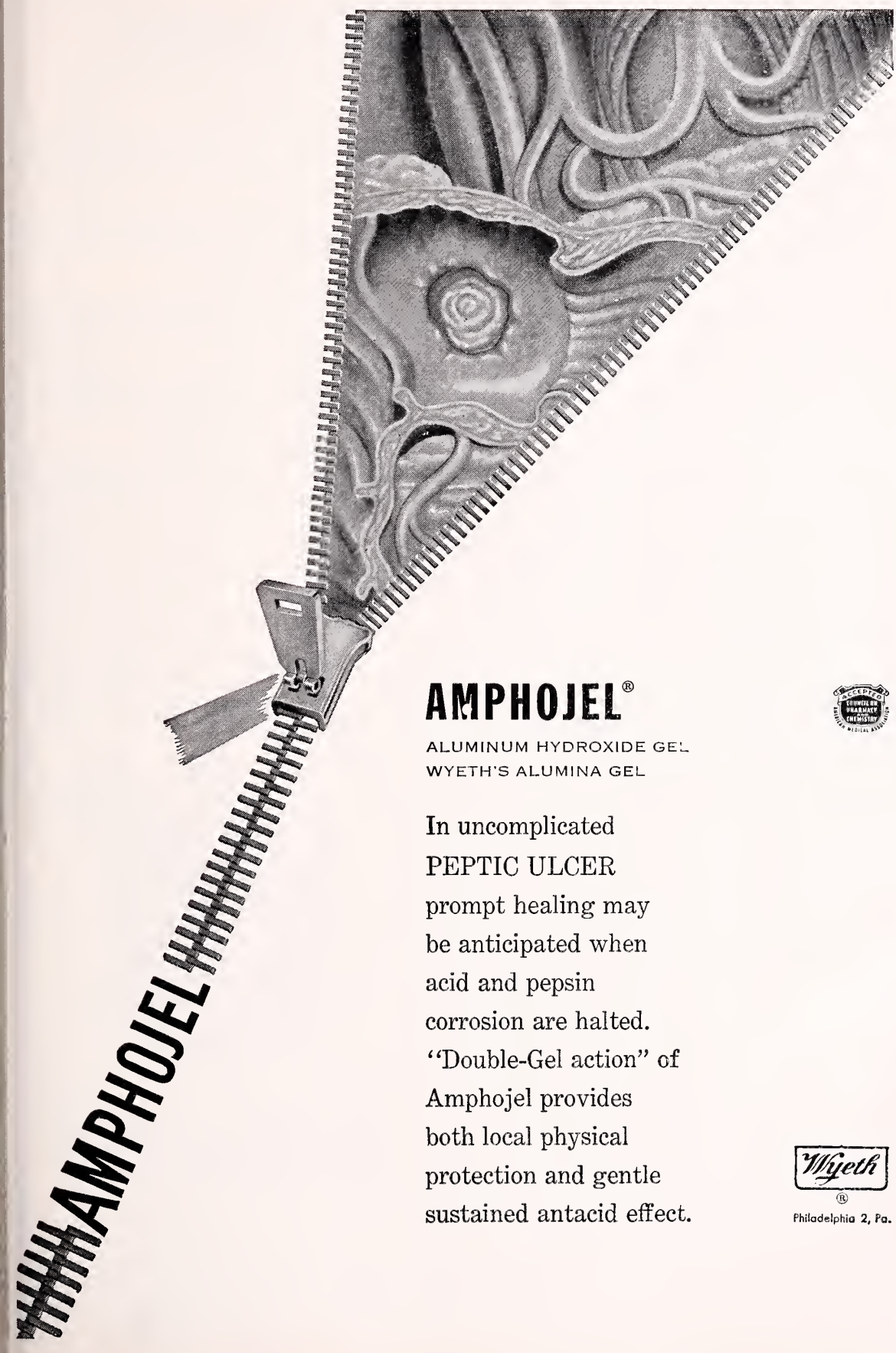
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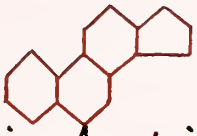
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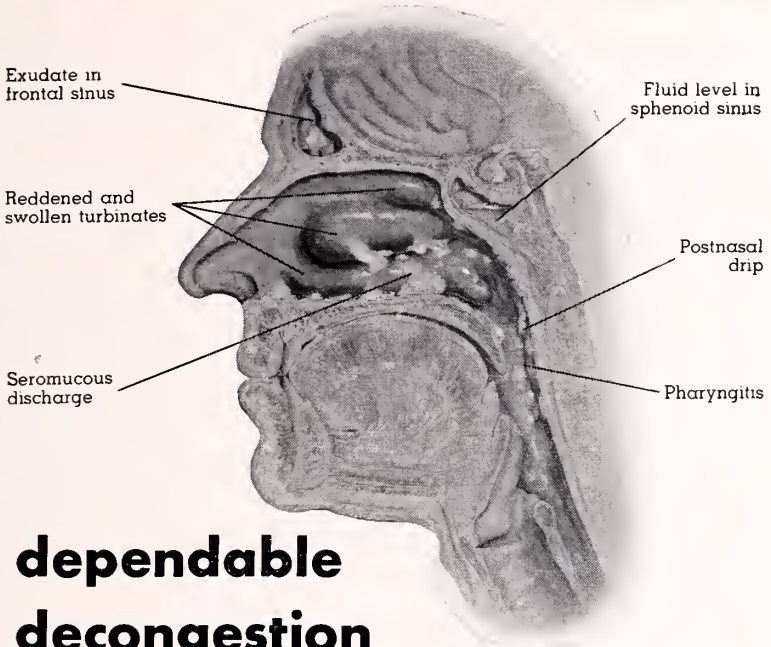
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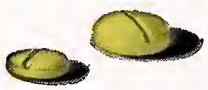
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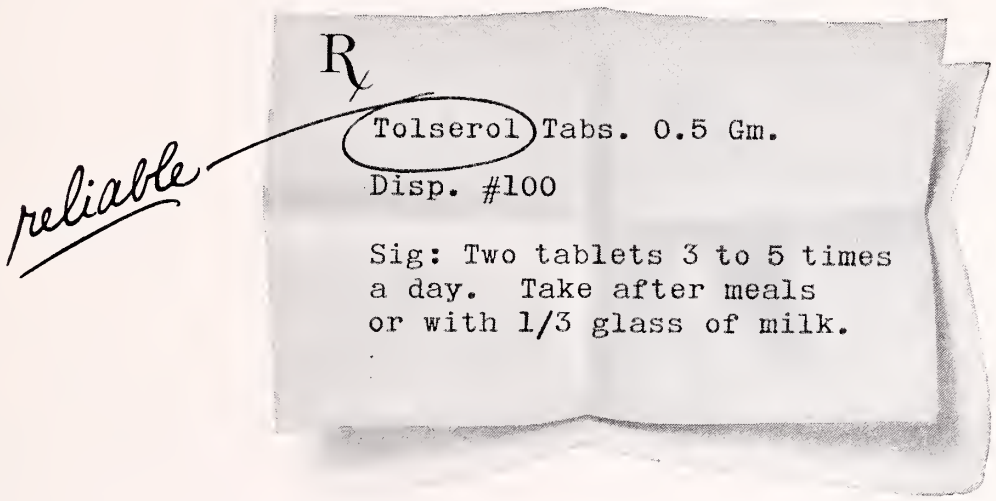
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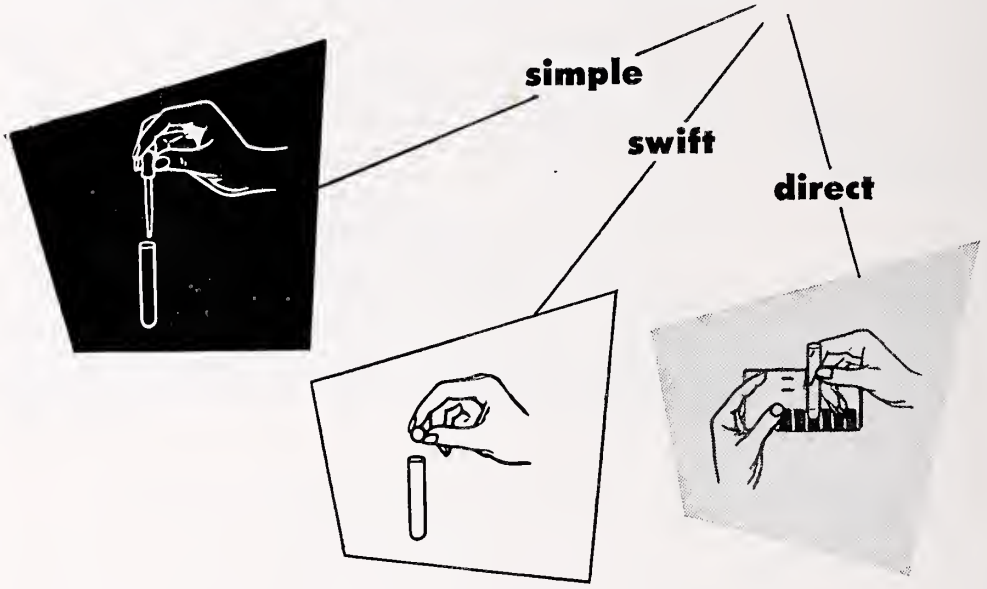
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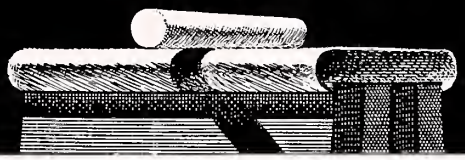
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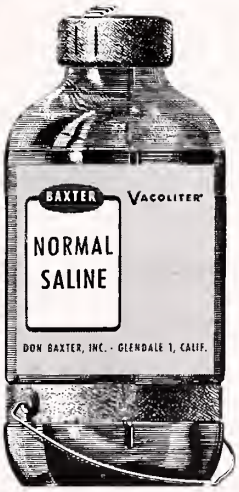


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# A COMPARATIVE STUDY OF THE MORTALITY FROM GASTRIC CANCER IN HAWAII

THEODORE R. RHEA, M.P.H.*
HONOLULU

THERE is good evidence that the incidence of cancer, and especially cancer of various sites, differs among certain ethnic groups throughout the world. The relatively low incidence of cancer of the cervix in Jewish women and the high incidence of cancer of the skin in north European countries are notable examples.

Several recent references in medical literature suggest that Japanese may have an unusually high incidence of cancer of the stomach in their native land as well as in Hawaii and California.

Two unpublished studies made in Hawaii approximately twenty years ago strongly indicated that the mortality rate from cancer of the stomach among Japanese was higher than in other racial groups.

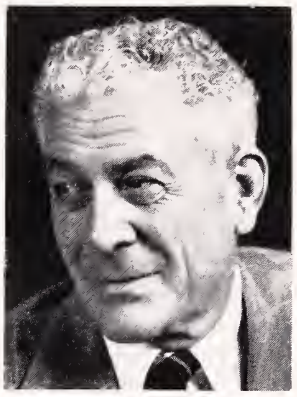
One study by Larsen[1] in 1930 suggested that the incidence of cancer of the stomach was higher in Japanese than in Caucasians. Another study made by Flude, Little and Stone[2] for the period 1930-34 inclusive indicated a somewhat higher mortality rate for cancer of the digestive tract in Japanese than in other ethnic groups.

Since the Japanese in Hawaii were a relatively young population at the time of these studies, the crude mortality rate used as a means of comparison did not reflect the true differences. Had age-corrected rates or specific rates for age and sex been computed for the various ethnic groups, the difference would have been much more striking.

In more recent years Wangensteen,[3] in his monograph on cancer of the esophagus and stomach, calls attention to the unusually high percentage of deaths from cancer of the stomach in Japan and Norway.

Strode,[4] reporting on a study of 500 operations involving the stomach (approximately 300 non-Japanese and 200 Japanese) in Honolulu, found that "gastric carcinoma was twice as common in the Japanese as compared with other races . . ."

Steiner[5] recently studied 35,293 necropsies performed at the Los Angeles County Hospital. Of these, 741 necropsies were for gastric cancer. Comparisons were made of the racial incidence of cancer among "Caucasoid, Negroid and Mongoloid (separate analyses for Japanese, Chinese and Filipino) and in Mexicans . . . the incidence was about three times greater in Japanese than in Caucasoid . . ."



MR. RHEA

A morbidity study of 2,773 records of patients with malignant tumors being conducted by the Territorial Department of Health and the Hawaii Medical Association indicates that Japanese males have a higher percentage of cancer of the stomach than other ethnic groups studied. This study, as yet unpublished, is under the direction of Doctors Quisenberry, Tilden, and Rosengard.[6]

Many physicians in Hawaii feel that cancer of the stomach is commoner in Japanese, especially the men, than in non-Japanese living in the islands. Other physicians are unwilling to accept this theory as they feel that scientific statistical evidence is lacking.

### Purpose of Study

The purpose of this study is to determine, by specific age and sex mortality rates, whether the mortality rate from cancer of the stomach is higher in Japanese than in non-Japanese living in Hawaii. As a by-product of this study, specific mortality rates were also determined for cancer deaths of all sites and for cancer deaths other than cancer of the stomach.

The study is based entirely on mortality data derived from official death certificates recorded at the Bureau of Health Statistics, Territorial Department of Health. No attempt has been made

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* Executive Director, Hawaii Cancer Society.

[1] Larsen, N. P.: Cancer, 1930, unpublished (Available at Honolulu County Medical Library).

[2] Flude, J. M., Little, C. C., and Stone, J. G.: Cancer Survey for the Territory of Hawaii, unpublished (Available at Hawaii Cancer Society).

[3] Wangensteen, O. H.: Cancer of the Esophagus and Stomach, A Monograph for the Physician, published by the American Cancer Society, 1951 (Available at Hawaii Cancer Society).

[4] Strode, J. E.: Observations on Cancer of the Stomach in Hawaii, A Study of 140 Consecutive Cases Coming to Surgery, HAWAII MED. J. 10:173 (Jan.-Feb.) 1951.

[5] Steiner, P. E.: Ethnic Implications of the Ratio Incidences of Gastric Cancer, Bureau of National Cancer Institute, 10:429 (Oct.) 1949.

[6] Quisenberry, W., Tilden, I. L., and Rosengard, J. L.: A Study of Cancer Morbidity in Hawaii, Territorial Department of Health and Hawaii Medical Association, unpublished (Available at Bureau of Cancer Control, Territorial Department of Health).

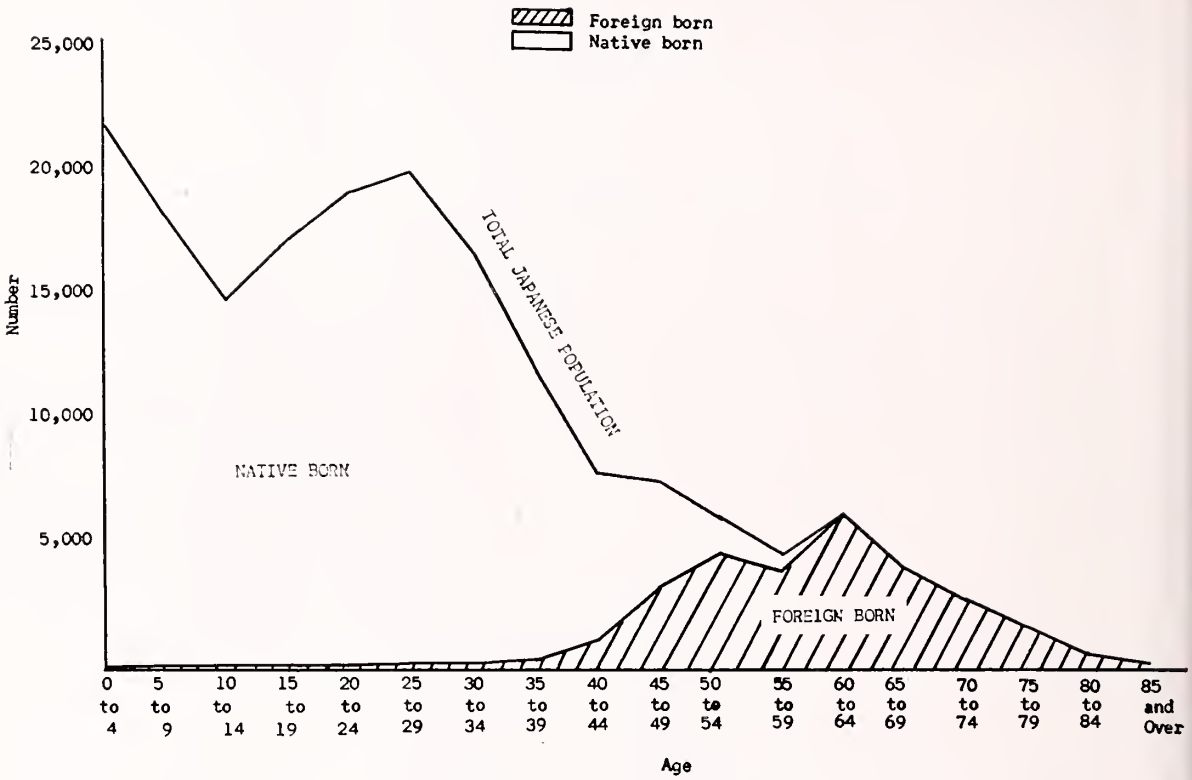



FIG. 1—Age distribution of the Japanese population in Hawaii based on 1950 U. S. Census.

at this point to ascertain the method or methods physicians used in determining the diagnosis appearing on the death certificate.

The study included all cancer deaths reported to the Health Department from January 1, 1948 to December 31, 1952.

The overall distribution of the deaths included in the study is as follows:

| | | |
|---|---|---|
| Deaths, Cancer—All sites | | |
| Total deaths | 2201 | |
| Male deaths | 1394 | 63.3% |
| Female deaths | 807 | 36.7% |
| Japanese deaths | 976 | 44.3% |
| Non-Japanese | 1225 | 55.7% |
| Deaths, Cancer of the stomach— 25 per cent of all cancer deaths | | |
| Total deaths | 551 | |
| Male deaths | 396 | 71.9% |
| Female deaths | 155 | 28.1% |
| Deaths, Other than cancer of the stomach | | |
| Total deaths | 1650 | |
| Male deaths | 998 | 60.5% |
| Female deaths | 652 | 39.5% |

## Population

Before entering into the details of this study, a brief description of the Japanese and non-Japanese population in Hawaii might well be given. Large waves of Japanese immigrants came to Hawaii during the latter part of the nineteenth century and the earlier part of the twentieth century. The men came first as agricultural workers. Some served out their contracts and returned to Japan, while others elected to make Hawaii their permanent home. Those who remained soon sent to their homeland for wives and immediately settled down to building homes and raising families. The Japanese women who came to Hawaii were on the average five years younger than the men. In 1950, the median age of the foreign-born Japanese woman was 57.8 years as compared with the male median of 62.6 years. The Japanese is the largest ethnic group in Hawaii, composing 36.9 per cent of the total population.

The non-Japanese population consists of several ethnic groups in the following descending order of size: Caucasian, Hawaiian and part-Hawaiian, Filipino, Chinese, and all others. The Japanese primarily concerned in this study (over 45 years of age) are not mixed with other races, while the non-Japanese population consists of a high percentage of mixtures of one type or another.

Figure 1 shows the age distribution of native-born and foreign-born segments of the Japanese population in Hawaii according to the 1950 U. S. census. It will be readily noted that the foreign-born population is concentrated in the older age

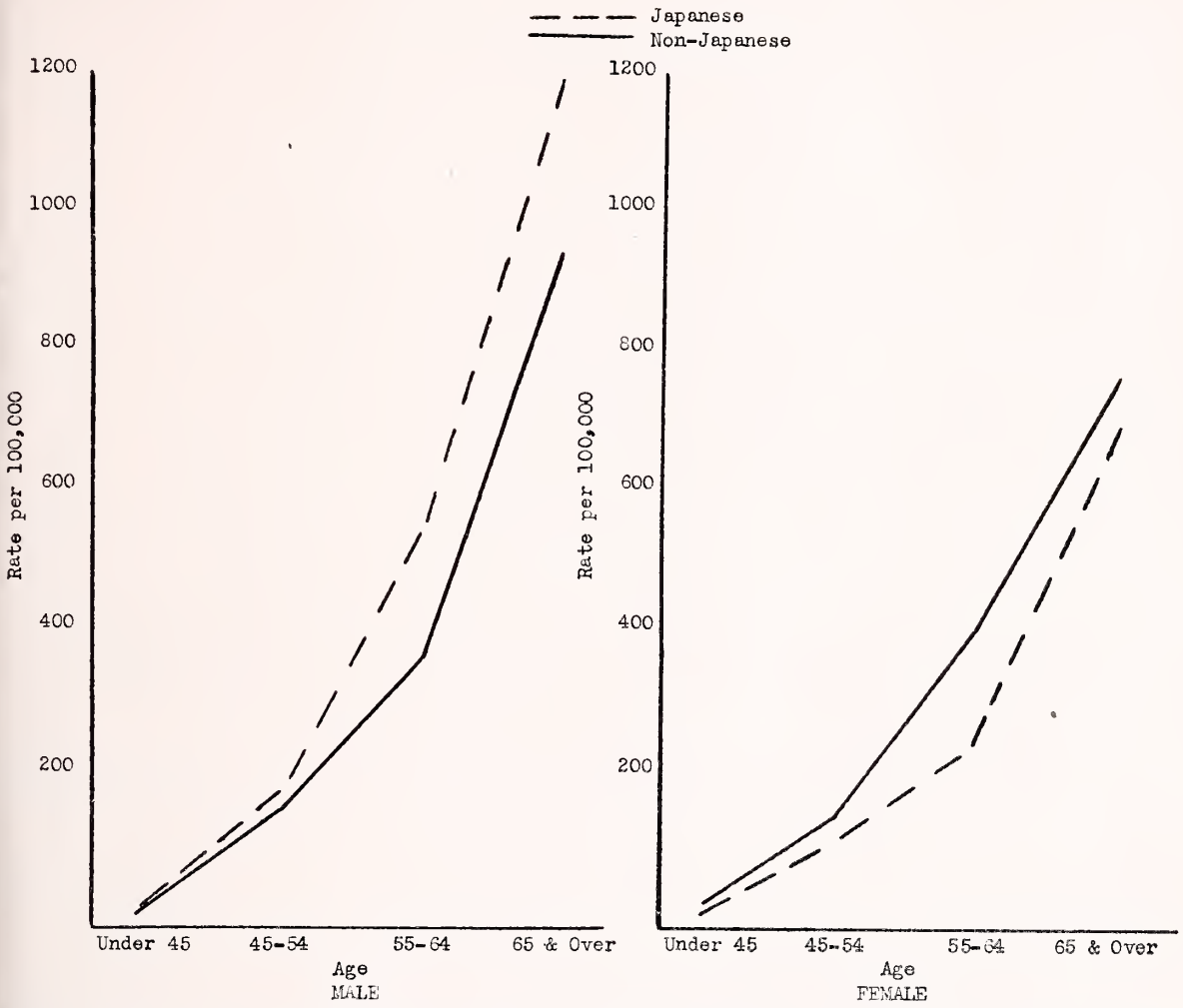



FIG. 2—Mortality rates for *cancer of all sites* in Hawaii, comparing Japanese with non-Japanese. Annual mortality rate based on 5-year average (1948-1952 inc.).

groups in which cancer, especially of the stomach, is most prevalent. Only a small percentage of the native-born population has entered this age period.

An effort was made to compare the incidence of cancer in native-born with foreign-born but because of this age distribution, there were not enough deaths in the native-born to make such a study possible.

The basic data obtained from the Health Department did not include cancer deaths in the armed forces. The 1950 U. S. census used in computing rates, however, did include 22,570 military personnel. An examination of the age distribution of the military personnel indicates that practically all (98 per cent) were under the age of 45. Since our study is concerned almost entirely with persons 45 years of age and over, we believe that the use of the U. S. census figures as they stand does not affect the results obtained in the study.

### Timing

The timing of this study had certain definite advantages.

1. It involves the most recent available data.
2. The last five years have been relatively quiet, with no large scale movements of either the Japanese or non-Japanese segments of the population similar to those which occurred before, during and immediately following World War II.
3. There is a real advantage in centering a study of this type on the year of the U.S. census, rather than later in the intercensus period, thus avoiding the necessity of using estimated population data.

In order to keep the number of deaths relatively large, ten-year age intervals were used. Deaths under 45 as well as those over 65 were grouped for the same purpose.

### Age Specific Mortality Rates

Figure 2 indicates that Japanese men have higher age specific mortality rates for cancer of all sites than non-Japanese men at specific age

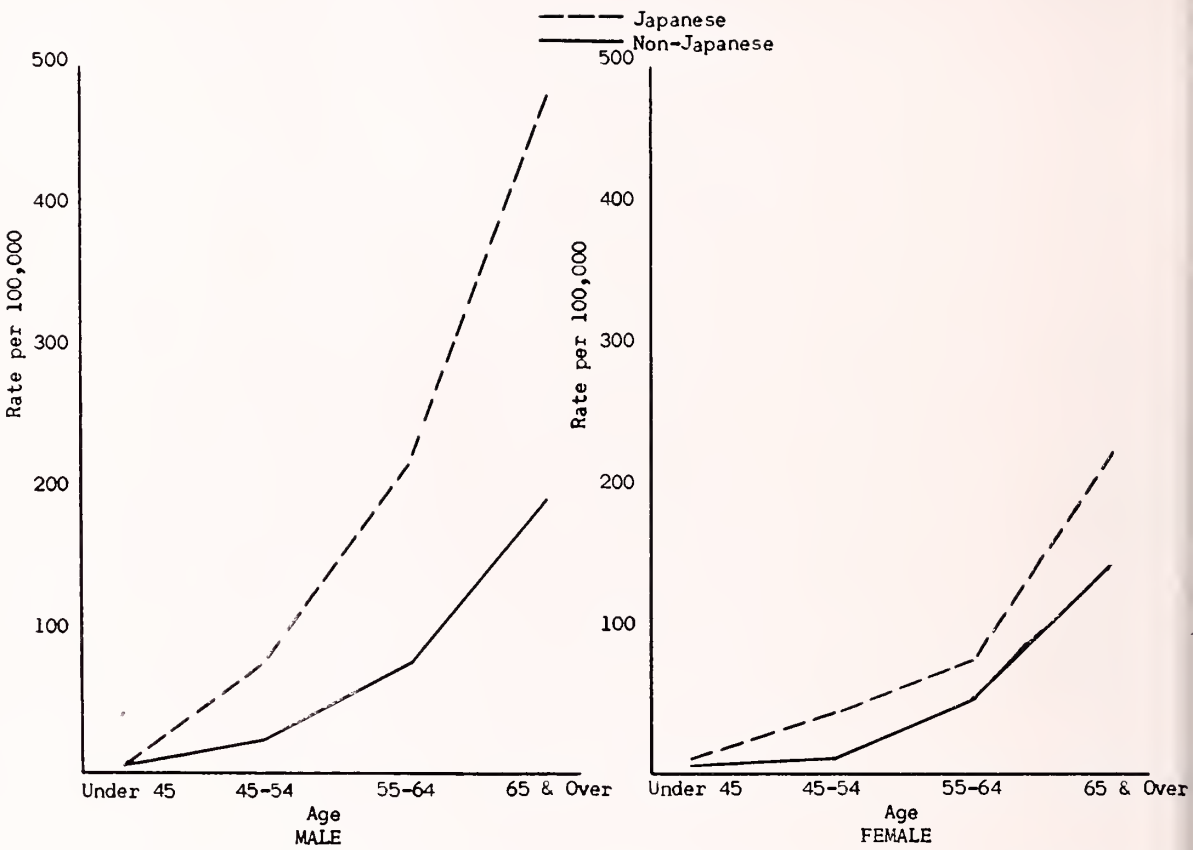



FIG. 3—Mortality rates for *cancer of the stomach* in Hawaii, comparing Japanese with non-Japanese. Annual mortality rate based on 5-year average (1948-1952 inc.).

levels 45 years of age and over, while Japanese women appear to have somewhat lower rates than non-Japanese women for cancer of all sites at these age levels.

Figure 3 indicates that Japanese men have significantly higher mortality rates than non-Japanese men from cancer of the stomach in age brackets 45 years of age and above. Japanese women appear to have a higher mortality rate from cancer of the stomach than non-Japanese women although the proportionate difference is not as large as in the men.

When mortality from cancer of the stomach was excluded and rates computed for cancer deaths other than stomach, it was found (Figure 4) that the rates for Japanese men are very similar to the non-Japanese men and Japanese women appeared to have lower rates than non-Japanese women.

The statistical significance of the above differences is discussed in paragraph 3 under Comments.

Since sex as well as age is an important factor in cancer of the stomach, it is interesting to note that Japanese men over 45 years of age have a rate (256.3) which is 2.6 times the female rate (98.0) for the same age group, while the rate (69.2) for the non-Japanese males is only 1.46 times the female rate (47.4) for this age.

## Comments

1. We recognize the fact that death certificate diagnoses are not entirely reliable when unsupported by other evidence, especially in a disease as difficult to diagnose as cancer of the stomach. We would expect, however, that inaccuracies in diagnosis would be distributed more or less evenly throughout both the Japanese and non-Japanese, and we find no evidence to the contrary. Generally speaking, Hawaii has excellent medical and hospital facilities. Reporting of deaths is probably as good as anywhere else in the United States. In 1949 a law was passed by the Territorial Legislature requiring autopsies on all unattended deaths. In order to avoid possibility of error in diagnosis, efforts are now under way to determine how the diagnosis was made in deaths from cancer of the stomach and whether the diagnoses were as accurately made in the Japanese as in the non-Japanese group. The results of this study will be reported later.

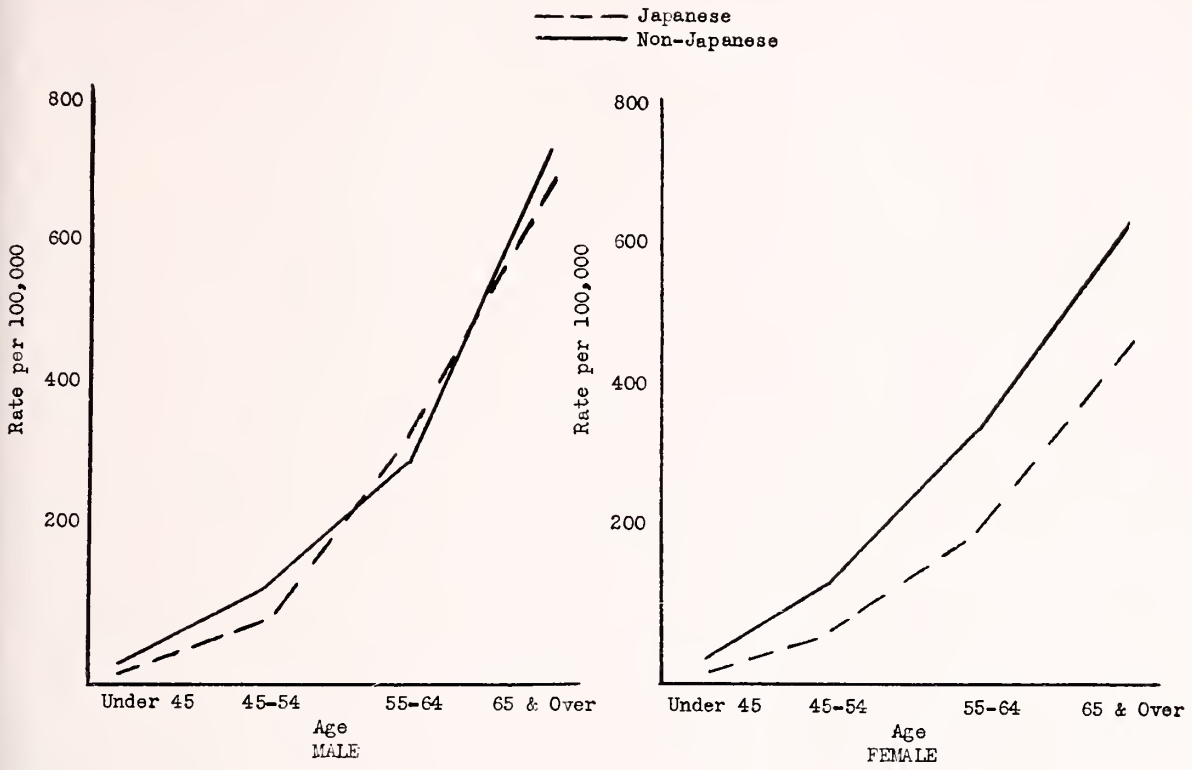



FIG. 4—Mortality rates for *cancer other than stomach* in Hawaii, comparing Japanese with non-Japanese. Annual mortality rate based on 5-year average (1948-1952 inc.).

2. While other studies have the advantage over our study of having a clear cut diagnosis on each case, we believe our study has the advantage of dealing with comparatively large numbers and includes all reported deaths over a given period of time (5 years) in a total community (Hawaii).
3. We realize that conclusions cannot be drawn from a study of this type without the application of standard statistical tests of reliability. Differences between the mortality rates in the various groups studied were tested with both the Chi square method and the T ratio. For the purpose of brevity, we are reporting only the results of the T ratio. However, it is worth noting that the Chi squares substantiate our findings with the T ratio. Since a large percentage of the cancer deaths occurred after 45 years of age, the tests were applied to the mortality rate 45 years and over.

TABLE 1. *Standard Error and T Ratio of Mortality Rates.*

| SITE | OBSERVED DEATH RATES (45 YRS. & OVER) | DIFFERENCE BETWEEN DEATH RATES | S.E. OF DEATH RATES | T RATIO* |
|---|---|---|---|---|
| *All Sites* | | | | |
| Japanese—Males | 630.1 | 278.0 | ± 58.0 | 4.20 |
| Non-Japanese—Males | 352.1 | | ± 32.0 | |
| Japanese—Females | 312.3 | 43.5 | ± 41.3 | .73 |
| Non-Japanese—Females | 355.8 | | ± 43.5 | |
| *Stomach* | | | | |
| Japanese—Males | 256.3 | 187.1 | ± 36.8 | 4.72 |
| Non-Japanese—Males | 69.2 | | ± 13.8 | |
| Japanese—Females | 98.0 | 50.6 | ± 24.5 | 1.76 |
| Non-Japanese—Females | 47.4 | | ± 15.0 | |
| *Other than Stomach* | | | | |
| Japanese—Males | 373.8 | 90.0 | ± 44.6 | 1.71 |
| Non-Japanese—Males | 282.9 | | ± 28.6 | |
| Japanese—Females | 214.3 | 89.3 | ± 37.9 | 1.70 |
| Non-Japanese—Females | 303.6 | | ± 36.3 | |

* A T ratio of 2 or more is an acceptable indication that a difference is significant.

It will be noted in Table 1 that the difference between Japanese and non-Japanese mortality rates in males from cancer of all sites and cancer of the stomach is highly significant. Other differences, while they are not large enough to be considered statistically significant, may well have some meaning. This is particularly true because a 5-year average was used to determine the annual mortality rates and the total number of deaths as well as population samples was fairly large.

A Chi square of 6.926 computed on the bases of sex and race (conclusion 2) indicates a significant difference in the sex ratio between the Japanese and non-Japanese.

## Conclusions

Based entirely on data derived from death certificates without confirmation of the method of diagnosis, and rates computed on the 1950 census, the following statistically significant conclusions are drawn:

1. Japanese males 45 years of age and over in Hawaii have a significantly higher mortality rate than non-Japanese males of the same age from cancer of all sites. The higher mortality rate in Japanese males

TABLE 2. *Cancer Deaths in Hawaii* 1948 to 1952 Inclusive.*

ALL SITES

JAPANESE

| | 1948 | | 1949 | | 1950 | | 1951 | | 1952 | | 5 YEAR TOT. | | 5 YEAR AV. | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | M | F | M | F |
| All Ages | 125 | 72 | 131 | 58 | 137 | 60 | 122 | 65 | 138 | 68 | 653 | 323 | 131 | 64 |
| Under 45 | 12 | 12 | 12 | 15 | 9 | 13 | 13 | 11 | 17 | 16 | 63 | 67 | 12 | 13 |
| 45 and Over | 113 | 60 | 119 | 43 | 128 | 47 | 109 | 54 | 121 | 52 | 590 | 256 | 118 | 51 |
| 45 to 54 | 13 | 11 | 15 | 6 | 12 | 7 | 9 | 8 | 13 | 11 | 62 | 43 | 12 | 9 |
| 55 to 64 | 37 | 16 | 36 | 14 | 35 | 16 | 25 | 10 | 22 | 16 | 155 | 72 | 31 | 14 |
| 65 and Over | 63 | 33 | 68 | 23 | 81 | 24 | 75 | 36 | 86 | 25 | 373 | 141 | 75 | 23 |

NON-JAPANESE

| | 1948 | | 1949 | | 1950 | | 1951 | | 1952 | | 5 YEAR TOT. | | 5 YEAR AV. | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | M | F | M | F |
| All Ages | 158 | 85 | 119 | 105 | 162 | 87 | 157 | 113 | 145 | 94 | 741 | 484 | 148 | 97 |
| Under 45 | 33 | 17 | 16 | 25 | 29 | 24 | 27 | 26 | 24 | 18 | 129 | 110 | 26 | 22 |
| 45 and Over | 125 | 68 | 103 | 80 | 133 | 63 | 130 | 87 | 121 | 76 | 612 | 374 | 122 | 75 |
| 45 to 54 | 30 | 12 | 24 | 17 | 35 | 15 | 33 | 27 | 33 | 17 | 155 | 88 | 31 | 18 |
| 55 to 64 | 27 | 19 | 36 | 30 | 38 | 21 | 43 | 30 | 28 | 24 | 172 | 124 | 34 | 25 |
| 65 and Over | 68 | 37 | 43 | 33 | 60 | 27 | 54 | 30 | 60 | 35 | 285 | 162 | 57 | 32 |

STOMACH

JAPANESE

| | 1948 | | 1949 | | 1950 | | 1951 | | 1952 | | 5 YEAR TOT. | | 5 YEAR AV. | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | M | F | M | F |
| All Ages | 51 | 21 | 49 | 14 | 60 | 19 | 46 | 14 | 51 | 26 | 257 | 94 | 51 | 18 |
| Under 45 | 2 | 1 | 2 | 4 | 1 | 1 | 1 | 0 | 10 | 6 | 16 | 12 | 3 | 2 |
| 45 and Over | 49 | 20 | 47 | 10 | 59 | 18 | 45 | 14 | 41 | 20 | 241 | 82 | 48 | 16 |
| 45 to 54 | 9 | 3 | 6 | 2 | 7 | 3 | 3 | 4 | 6 | 4 | 31 | 16 | 6 | 3 |
| 55 to 64 | 15 | 6 | 16 | 2 | 17 | 5 | 7 | 3 | 6 | 4 | 61 | 20 | 12 | 4 |
| 65 and Over | 25 | 11 | 25 | 6 | 35 | 10 | 35 | 7 | 29 | 12 | 149 | 46 | 30 | 9 |

NON-JAPANESE

| | 1948 | | 1949 | | 1950 | | 1951 | | 1952 | | 5 YEAR TOT. | | 5 YEAR AV. | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | M | F | M | F |
| All Ages | 36 | 12 | 21 | 12 | 25 | 13 | 28 | 14 | 29 | 10 | 139 | 61 | 27 | 12 |
| Under 45 | 8 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 2 | 0 | 17 | 10 | 3 | 2 |
| 45 and Over | 28 | 10 | 19 | 10 | 23 | 10 | 25 | 11 | 27 | 10 | 122 | 51 | 24 | 10 |
| 45 to 54 | 6 | 0 | 5 | 1 | 3 | 2 | 6 | 2 | 8 | 2 | 28 | 7 | 5 | 1 |
| 55 to 64 | 4 | 4 | 3 | 2 | 10 | 4 | 10 | 4 | 6 | 3 | 33 | 17 | 7 | 3 |
| 65 and Over | 18 | 6 | 11 | 7 | 10 | 4 | 9 | 5 | 13 | 5 | 61 | 27 | 12 | 6 |

ALL SITES OTHER THAN STOMACH

JAPANESE

| | 1948 | | 1949 | | 1950 | | 1951 | | 1952 | | 5 YEAR TOT. | | 5 YEAR AV. | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | M | F | M | F |
| All Ages | 74 | 51 | 82 | 44 | 77 | 41 | 76 | 51 | 87 | 42 | 396 | 229 | 79 | 46 |
| Under 45 | 10 | 11 | 10 | 11 | 8 | 12 | 12 | 11 | 7 | 10 | 47 | 55 | 9 | 11 |
| 45 and Over | 64 | 40 | 72 | 33 | 69 | 29 | 64 | 40 | 80 | 32 | 349 | 174 | 70 | 35 |
| 45 to 54 | 4 | 8 | 9 | 4 | 5 | 4 | 6 | 4 | 7 | 7 | 31 | 27 | 6 | 5 |
| 55 to 64 | 22 | 10 | 20 | 12 | 18 | 11 | 18 | 7 | 16 | 12 | 94 | 52 | 19 | 11 |
| 65 and Over | 38 | 22 | 43 | 17 | 46 | 14 | 40 | 29 | 57 | 13 | 224 | 95 | 45 | 19 |

NON-JAPANESE

| | 1948 | | 1949 | | 1950 | | 1951 | | 1952 | | 5 YEAR TOT. | | 5 YEAR AV. | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | M | F | M | F |
| All Ages | 122 | 73 | 98 | 93 | 137 | 74 | 129 | 99 | 116 | 84 | 602 | 423 | 120 | 84 |
| Under 45 | 25 | 15 | 14 | 23 | 27 | 21 | 24 | 23 | 22 | 18 | 112 | 100 | 22 | 20 |
| 45 and Over | 97 | 58 | 84 | 70 | 110 | 53 | 105 | 76 | 94 | 66 | 490 | 323 | 98 | 64 |
| 45 to 54 | 24 | 12 | 19 | 16 | 32 | 13 | 27 | 25 | 25 | 15 | 127 | 81 | 25 | 16 |
| 55 to 64 | 23 | 15 | 33 | 28 | 28 | 17 | 33 | 26 | 22 | 21 | 139 | 107 | 28 | 21 |
| 65 and Over | 50 | 31 | 32 | 26 | 50 | 23 | 45 | 25 | 47 | 30 | 224 | 135 | 45 | 27 |

* Data obtained through the courtesy of the Hawaii Territorial Department of Health.

TABLE 3. *Death Rates per 100,000 Population by Age and Sex for Cancer of All Sites, Stomach and All Sites Other Than Stomach.*

| AGE | JAPANESE MALES ALL SITES | JAPANESE MALES STOMACH | JAPANESE MALES OTHER THAN STOMACH | JAPANESE FEMALES ALL SITES | JAPANESE FEMALES STOMACH | JAPANESE FEMALES OTHER THAN STOMACH |
|---|---|---|---|---|---|---|
| All Ages | 140.5 | 54.7 | 84.7 | 70.1 | 19.7 | 50.4 |
| Under 45 | 16.1 | 4.0 | 12.1 | 17.3 | 2.7 | 14.7 |
| 45 and Over | 630.1 | 256.3 | 373.8 | 312.3 | 98.0 | 214.3 |
| 45-54 | 177.6 | 88.8 | 88.8 | 126.8 | 42.3 | 70.4 |
| 55-64 | 547.6 | 212.0 | 335.6 | 264.3 | 75.5 | 207.7 |
| 65 and Over | 1188.4 | 475.4 | 713.0 | 712.1 | 228.9 | 483.2 |

| AGE | NON-JAPANESE MALES ALL SITES | NON-JAPANESE MALES STOMACH | NON-JAPANESE MALES OTHER THAN STOMACH | NON-JAPANESE FEMALES ALL SITES | NON-JAPANESE FEMALES STOMACH | NON-JAPANESE FEMALES OTHER THAN STOMACH |
|---|---|---|---|---|---|---|
| All Ages | 81.9 | 14.9 | 66.4 | 72.1 | 8.9 | 62.4 |
| Under 45 | 17.8 | 2.1 | 15.1 | 19.4 | 1.8 | 17.6 |
| 45 and Over | 352.2 | 69.2 | 282.9 | 355.8 | 47.4 | 303.6 |
| 45-54 | 160.6 | 25.9 | 129.5 | 161.7 | 9.0 | 143.8 |
| 55-64 | 366.7 | 75.5 | 302.0 | 427.6 | 51.3 | 359.2 |
| 65 and Over | 939.4 | 197.8 | 741.6 | 779.2 | 146.1 | 657.4 |

TABLE 4. *Population of Hawaii for Japanese and non-Japanese by Age and Sex According to the 1950 U. S. Census.*

| | JAPANESE MALE | JAPANESE FEMALE | JAPANESE TOTAL | NON-JAPANESE MALE | NON-JAPANESE FEMALE | NON-JAPANESE TOTAL |
|---|---|---|---|---|---|---|
| All Ages | 93,246 | 91,352 | 184,598 | 180,625 | 134,546 | 315,171 |
| Under 45 | 74,519 | 75,023 | 149,542 | 145,982 | 113,464 | 259,446 |
| 45 & Over | 18,727 | 16,329 | 35,056 | 34,643 | 21,082 | 55,725 |
| 45-54 | 6,755 | 7,100 | 13,855 | 19,303 | 11,129 | 30,432 |
| 55-64 | 5,661 | 5,297 | 10,958 | 9,272 | 5,846 | 15,118 |
| 65 & Over | 6,311 | 3,932 | 10,243 | 6,068 | 4,107 | 10,175 |

| | ALL RACES MALE | ALL RACES FEMALE | ALL RACES TOTAL |
|---|---|---|---|
| All Ages | 273,871 | 225,898 | 499,769 |
| Under 45 | 220,501 | 188,487 | 408,988 |
| 45 and Over | 53,370 | 37,411 | 90,781 |
| 45-54 | 26,058 | 18,229 | 44,287 |
| 55-64 | 14,933 | 11,143 | 26,076 |
| 65 and Over | 12,379 | 8,039 | 20,418 |

is due almost entirely to their higher mortality from cancer of the stomach.

2. The mortality rate for Japanese males over 45 years of age, as compared with Japanese females, is significantly larger than the proportionate difference between the male and female rates in the non-Japanese groups of the same age bracket.

## Acknowledgments

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# PRIMARY CARCINOMA OF THE LIVER

## A Statistical Review of Twelve Cases Seen at The Queen's Hospital, 1947 to 1952

J. G. MARNIE, M.D.
HONOLULU

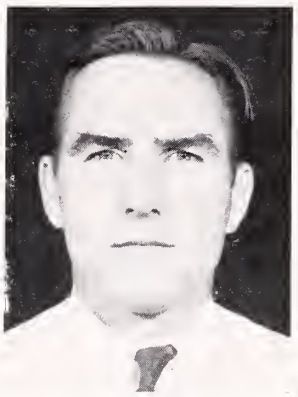
ROKITANSKY first distinguished between primary and secondary hepatic malignancy in 1849. It was not until 1876 that clinical details began to be recorded, when Kelsh and Kiener reported two cases of primary neoplasm of the liver.[1] In 1911 Goldzieher and Von Bokay brought forth the terms "hepatocellular" and "cholangiocellular," the terminology which seems to have stood the test of time. Yamigawa in the same year coined the less precise words "hepatoma" and "cholangioma." At a later date Ewing[2] introduced the term "mixed tumor" to indicate both liver cell and bile duct cell carcinoma in the same neoplasm.

The first successful resection of a primary malignancy of the liver was accomplished by Lücke[3] in 1891. Keen in 1899 was the first American surgeon to perform a successful resection.

In 1901 Eggel, in a review of the literature, could find only 163 cases on record, many of these of doubtful validity, while Ochsner[1] in 1947 had collected 1,616 cases proven histologically. Although not one of the commoner abdominal neoplasms, hepatoma is not rare.

It is impossible to speak specifically of the true incidence of primary carcinoma of the liver, because of the absence of any uniform diagnostic criteria and the fact that most statistical records group tumors of the gall bladder, bile ducts and liver under one heading.

Most evidence seems to support the belief that this is a disease predominating in the yellow and dark races. Hartz[4] has shown that the Chinese tend to carry with them this predisposition even when separated from their native habitat. The sex incidence is predominantly male and all reports confirm this without argument. Wilbur[5] and associates report 96 per cent male predominance in a 40-case series. Primary carcinoma of the liver has been reported at ages of from 3 days[6] to 85 years.[1] Although the range is wide, most cases seem to occur during and after middle life.



DR. MARNIE

A statistical review of the records of The Queen's Hospital for a five year period, 1947 to 1952, revealed a total of 14 cases of primary hepatic malignancy. Two of these cases could not be supported with tissue studies, so that the histologically proven cases total 12 or about 2.4 cases per year. Ages ranged from 35 to 81 years and averaged 56 years. The racial breakdown showed 4 Chinese, 2 Japanese, 3 Filipinos, 1 Korean, 1 Hawaiian (pure) and 1 *haole* [white]. The Hawaiian was 35 years old, and the only case born in the Territory. There were 3 females and 9 males. Two of these neoplasms were of the cholangioma or bile duct cell type and ten were of the liver cell type or hepatoma. It is realized that this series is small and probably of little significance; however, it does conform in percentages with a majority of the larger series, except that 25 per cent of our cases have been females, which is rather high.

The nature of this disease makes follow-up studies a very simple matter. Of the twelve proven cases here reported, eleven are now dead as a direct result of their disease. The time lapse between histologic diagnosis and death averaged six weeks. The time lapse between onset of their chief complaint and death averaged seventeen weeks.

One case is now living and apparently well eight months after a left hepatectomy. With indeed a guarded prognosis it might be well worth reporting this case.*

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Read before the Sixty-Third Annual Meeting of the Hawaii Territorial Medical Association, Wailuku, Maui, May 1, 1953.

[1] Rosenberg, D. M. L., and Ochsner, A.: Primary Carcinoma of the Liver; an Analysis of Fifty-five Autopsied Cases, the Record of a Case with Resection and Review of the Recent Literature, Surgery 24:1036 (Dec.) 1948.

[2] Ewing, J.: Neoplastic Diseases, 4th ed., Philadelphia, 1940. W. B. Saunders Co.

[3] Lücke: Cited by Keen, W. W.: Report of a Case of Resection of the Liver for Removal of a Neoplasm with a Table of Seventy-six Cases of Resection of the Liver for Hepatic Tumors, Ann. Surg. 30:267, 1899.

[4] Hartz, P. H.: Role of Schistosomiasis in the Etiology of Cancer of the Liver in the Chinese, Arch. Path. 39:1 (Jan.) 1945.

[5] Wilbur, D. L., Wood, D. A., and Willett, F. M.: Primary Carcinoma of the Liver, Ann. Int. Med. 20:453 (Mar.) 1944.

[6] Widerhafer: Cited by Steiner, M. M.: Primary Carcinoma of the Liver in Childhood: Report of Two Cases with Critical Review of the Literature, Am. J. Dis. Child. 55:807 (Apr.) 1938.

* The twelfth case, described below, expired May 13, 1953, approximately nine months after hepatectomy.

Autopsy revealed extensive hepatomatosis was the actual cause of this man's death. It is interesting to note that at autopsy this man had an incidental grade two polypoid mucous adeno-carcinoma of the colon.

It is significant to note that he was quite comfortable up until approximately a week prior to his death and only entered the hospital the day before his death.

A 67 year old Korean man was seen in my office in October of 1952 complaining of pain in the epigastrium of intermittent nature of three months' duration. Another M.D. had been consulted for this during the first attack. There was no nausea or vomiting. No change in bowel or bladder habits had been noted, and the pain was not related to the taking of food or drink. He thought he had lost about fifteen pounds in the past three months. Physical examination revealed a moderately emaciated man in no acute distress. Temperature, blood pressure, pulse and respirations were normal. He did not appear to be jaundiced. There was a mass the size of one's fist in the left epigastrium which was slightly tender, firm, and felt crepitant. No metastatic nodes could be found. There was no Blumer shelf. Chest x-ray was negative.

The patient was sent to the hospital and there further studies were carried out. Blood counts and urine were normal. STS was 4+. Liver function was within normal limits. The roentgenologist's interpretation of an upper gastrointestinal series was "findings are consistent with an extensive malignant lesion involving the gastric cardia and pars media." The man was then prepared for a total gastric resection.

On exploration the tumor presented itself within the left lobe of the liver and displacement of the stomach was extreme. Exploration of the rest of the abdomen was negative. Biopsy of the lesion was then taken and a complete left hepatectomy performed without event. The raw surface of liver was reperitonealized with remnants of the falciform ligament, and the abdomen closed using three penrose rubber tissue drains through a stab wound in the right upper quadrant.

Pathologic diagnosis was hepatoma of the liver cell variety with cirrhosis of the liver. The patient made an uneventful recovery and left the hospital on the eleventh postoperative day. Regular follow up shows him to be enjoying good health with no signs of recurrence at the present time approximately eight months after resection.

The etiology of carcinoma of the liver is unknown. In primary neoplasms of the liver, however, there are certain other factors which are so constantly associated with the neoplasm they must be mentioned. Wilbur[5] and his group at Stanford, reporting a series of 40 cases, summarize it best, stating "the most important co-existing or perhaps contributing factor in the development of primary carcinoma of the liver is antecedent damage to the liver. In most instances this change is characterized by the presence of cirrhosis in all degrees from mild, so-called limited cirrhosis, to far advanced atrophic cirrhosis of Laennec. In some instances, damage to the liver was on a basis of toxic necrosis with subsequent healing."

Chronic hepatic irritation has been incriminated as a cause of hepatic malignancy. Specific irritants bearing the blame have been alcohol, toxic reagents, viral diseases, parasites, and of course syphilis. Hepatolithiasis[7] accompanying primary neoplasms of the liver has been offered as a possible cause, since the incidence of carcinoma of the gall bladder is increased in the presence of cholelithiasis. Congenital and hereditary factors have also been blamed.

The diagnosis of primary hepatic malignancy is not an easy one to make. It might be well to classify it as an urgent one in view of the rapidly fatal outcome of the disease. The fundamental and cardinal point in leading to the diagnosis is to constantly bear in mind that the condition exists. Especially here in Hawaii is this point important, the population differential as to race being what it is. Laboratory studies must be carried out in order to exclude other conditions but they will not aid materially in the positive diagnosis of hepatoma. Such symptoms as epigastric pain and distress, or abdominal distention with an enlarged liver and signs of cirrhosis, in people over 40, should make one extremely suspicious. A palpable undiagnosed mass in the area of the liver at any age should demand an exploratory operation. Needle biopsy and the peritoneoscope have not been used sufficiently in our hands to permit discussion.

Fortunately there is no argument as to the proper management of this condition, for without early surgery it is 100 per cent fatal. Every possible diagnostic aid should be employed and exploratory laparotomy resorted to without delay if suspicion of a primary neoplasm of the liver is present and cannot be excluded otherwise. Complete surgical excision offers the only hope for survival.

The prognosis is generally regarded as being poor, in that this is such a rapidly fatal neoplasm. Much too often the growth has gone well beyond the limits of surgery before exploratory is undertaken. Wallace,[8] in a report of 29 collected cases operated upon, showed there was a mortality of 20 per cent. Of the 20 patients followed, 12 or 60 per cent were alive two to five years after operation without recurrence.

## Summary

A statistical summary of 12 cases of primary carcinoma of the liver seen at The Queen's Hospital between 1947 and 1952 is presented. One case is reported wherein resection has been accomplished. A short review of primary carcinoma of the liver has been presented. That we in Hawaii are dealing with a racial background particularly susceptible to this disease should be obvious. It is hoped that this may stimulate us to faster and more accurate diagnosis in order that this rapidly fatal lesion may be offered a complete and thorough challenge here in the Territory of Hawaii.

[7] Sanes, S., and MacCallum, J. D.: Primary Carcinoma of the Liver; Cholangioma in Hepatolithiasis, Am. J. Path. 18:675 (July) 1942.

[8] Wallace, R. H.: Resection of Liver for Hepatoma, Arch. Surg. 43:14 (July) 1941.

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# THE LIMITATIONS OF MENTAL HYGIENE

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IF the eyes of man could see into the remote future as clearly as they view the past, and if man was not prone to project his anxieties into the distant unknown, what we call mental hygiene might have a slight chance of reaching its avowed goal of emotional security for everyone.



DR. STEPHENS

But to reach this state of doubtful bliss it would be necessary for the human mind to surrender its capacity to imagine, a priceless quality that differentiates man from all other animals. Lower animals have fears too, but they are the fears of the moment, logical fears of the predatory instincts of their kind. Only man can foresee in fancy a far-off day when he may be poor, hungry, sick, abandoned or unloved. Now, since this sense of personal insecurity has its roots in early life experiences and is really part of man's nature, it is to be doubted that any intellectual exercise will have a decisive or lasting effect.

### Anxiety and Guilt

Human anxiety begins the moment the infant first experiences a feeling of being abandoned when actually it is merely being left alone. This primary anxiety is revivified in later childhood when the little boy or girl comes to know, realistically or in phantasy, what it means to be disowned by the parents. This frightening experience may be fleeting, or last a lifetime, depending on the strength of the love the parents have for the child. But every child must pass through it, no matter how favorably situated or endowed, and even perfectionism in the parents could not prevent it.

Out of this experience there emerges another psychological force—a feeling of guilt that has its genesis in the thought "I must have done something bad to be unworthy of love." The psychological significance of these painful thoughts rests upon their intensity, the age at which they were experienced, and the sensitivity of the child. As a generality, they are swept back into the dark recesses of the unconscious, to remain there during the rest of life as the nucleus of man's personal insecurity. This knowledge helps us understand why guilt feelings are expressed in later life as anxiety, as self-derogatory thinking and behavior, or in feelings of inferiority.

Anxiety is not the same as fear, a primitive instinct that is useful and protective. Nor is it the same as insecurity, though it is far more likely to occur in the insecure person confronted by conditions of stress—a threat to one's safety or from loss of love, fortune, health and, most importantly, loss of self-esteem. Acute anxiety is insecurity in action.

### Insecurity

Emotional insecurity cannot be defined in terms of a specific personality disorder. It may manifest itself as a vague restlessness, a hunger for love or a search for peace; as a need for recognition and prestige which can be translated into the need to be wanted and approved. It may show itself as social fears in the form of shyness, bashfulness, timidity or meekness, or in dependence on alcohol and drugs. Personal insecurity is not synonymous with financial insecurity, though the latter may of course enhance the former if long continued or unusually severe. Yet the mere possession of money is not a protection against personal insecurity.

Is it feasible or desirable to prevent man's insecurity? It is not feasible, because each generation transmits, not to the offspring but to the environment, its own anxiety and guilt. But why can't this cycle be broken? It cannot be broken by persuasion or argument because the human mind functions on more than one psychological level. The conscious mind, which governs most of our waking hours, is the source of logic, reason, and will-power; and life would indeed be relatively simple (but awfully dull) if it alone decided our behavior. But there are other mental structures, each one having a delicate but powerful influence on the others.

### Preconscious and Unconscious

Speaking schematically, the layer below the conscious is the preconscious (also called the foreconscious or subconscious) which enriches life because it serves as a depository for the skills acquired by training—walking, eating, the dexterity learned in a trade or profession, artistic talent, athletic ability—in fact, all acts learned by repeti-

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tion but needed only under special conditions. Economically, this is a remarkable arrangement, since it permits the individual to act without pondering each step. The surgeon can perform a complex operation without devoting all of his attention to the technique. The athlete or musician can do difficult feats without wasting time contemplating each movement. At the same time, the preconscious is subject to conscious control, so that what is stored away can be changed, strengthened or given up according to the needs and desires of the individual.

The next layer, again speaking schematically, is the unconscious, a mental structure about which we hear so much yet know so little. What little is known has been learned from the sick mind, a fact that helps explain why abnormality can be defined whereas normality is still an unsolved mystery.

The unconscious is known by its effect on human thinking, feeling and behavior, just as we judge the capacity of neutrons and protons to create heat and energy. Many unseen forces must be appraised that way. In the human organism there still reside many unsolved puzzles, physiological reactions that cannot now be demonstrated.

There are a few reasonably certain facts about the unconscious, so that it does not have to be taken entirely on faith. It appears to be beyond ordinary ego control, is not open to self inspection or self interpretation, and, because it has only contempt for reality, is not governed by laws of logic or reason. It is ruthless in its search for satisfactions and, in the presence of neurotic guilt, just as relentless in seeking punishment. We have but to note the self-punitive behavior of the alcoholic and the criminal, the self-reproaches that appear so regularly in the depressions, or the feelings of inadequacy (sometimes over compensated) that are part of the strange constellation we call schizophrenia.

Whenever the ego is weak, the unconscious has a chance, one it does not neglect, to play a dominant role. In the severe psychoses the conscious mind may be entirely displaced by the unconscious. A growing body of knowledge is being accumulated out of this phenomenon.

So inaccessible and resistive is the unconscious, there is a temptation to become apodictical and say that mental hygiene is pretty much a waste of time. Yet this would be an over-statement, since there are limited areas in which educational measures can in time be fruitful, notably in the prevention of encephalitis, genetic epilepsy, cerebral arteriosclerosis, syphilis of the brain, pellagra, mental deficiency and certain other rarer organic conditions of the central nervous system. But since psychogenic disorders are neither infectious nor contagious, we cannot expect the brilliant results obtained in, let us say, diphtheria or typhoid fever.

Even the psychiatrist having access to genetic-dynamic principles in individual cases has fewer successes than failures. Verification of this is seen in the way psychiatry in desperation tries about anything that comes along in place of straight psychotherapy, including techniques that are certainly harmful to the patient (electric shock, lobotomies, Antabuse, etc.). It is difficult to say who is the more frustrated—the psychiatrist or the dermatologist.

It is not desirable to prevent insecurity by artificial means, because man does not want to be too secure; for in uncertainty he has come to recognize intuitively a tremendous driving psychological force without which life would have little meaning.

### Dangers of Security

To digress a moment: The zealous mental hygienist in search of a system that promises social security need not look very far. It is to be found in the perfect totalitarian state, for has not the leader said: "Follow me and obey and I shall satisfy all your needs." What he professes to guarantee is security in exchange for submissiveness—a tempting bait to the passive-dependent, ineffective, discontented, vindictive, baffled and frustrated person who childishly likes to believe there is a kind of magic in government. (The popular idea that poverty breeds communism is not in consonance with the obvious facts. There are many reasons why people are sucked into communism but poverty is among the least of these.)

To assure this promised security it is necessary to banish competition and thus eliminate man's aggressive striving for supremacy. In this "ideal" social system there would be no class distinctions, all subjects would be equal (except the politically elite) and, theoretically, feelings of inferiority and the aggression they evoke would no longer inhabit the members of such a protected group.

In this chimerical social organization there would finally emerge a spineless, compliant mass of individuals, hopelessly devoid of self-respect, caught in a vacuum of passivity. There is, moreover, another flaw in the picture of life in the promised land of security, for without a release for aggression its members would eventually turn

their hostility inward upon themselves to become emotionally or physically sick or destroy themselves at an even faster pace than mankind does in a free society, which, as every psychiatrist knows, is pretty fast indeed.

Dictators sense this need to find an outlet for hostility, to turn it away from themselves and towards other nations by fostering hatred for the rest of mankind. Persecution of minority groups (intellectuals, the wealthy, racial segments) within the dictatorship serves the same purpose.

Down through the centuries men have tried and rejected feudalism in its various guises even though it assured social security. It was rejected not necessarily because its vassals were mistreated —for in many cases, feudalism was benevolent— but because it represented an unbearable loss of self-esteem. Man prefers to be less secure, with freedom to love or hate, to be prejudiced or unbiased, to be vindictive or forgiving, to be extravagant or thrifty, to be greedy or generous, to be cruel or kind, to be lazy or ambitious, devout or irreligious; or, in short, to be anything he wants to be without coercion or force.

Once mankind becomes absolutely secure, the spirit of man will die. All the great achievements of the past, the creative arts and sciences, the urge to pioneer and explore, the wish to be different from the rest spring from a feeling of insecurity. It is the search for security that man needs more than security itself, for, paradoxically, as soon as security is found the human being becomes discontented and bored.

Confirmation of this strange phenomenon is seen in the behavior of the person who, upon completion of a successful undertaking, proceeds to destroy himself. We observe it in the man who has looked towards retirement all his life but who, upon finding himself free of anxiety no longer has a desire to live. We discern it in useless hoarding of senility or in the conduct of the person of inherited wealth who must compulsively dissipate a fortune through reckless investments, backing worthless causes, or alcoholism.

Everyone does not want or need emotional security. It is all right for babies and youngsters or the old and helpless. It is good for babies because it facilitates training and strengthens the ego. It is good for the elderly or the sick who may no longer be productive or able to compete with younger people. But a nation that emphasizes emotional security for its youth is in grave danger, for youth should be a time for blossoming hopes, daring adventure and a willingness to take chances. Who is going to defend the nation?

Like the stone of Sisyphus, man's emotional life cannot reach a goal of absolute security. Those that have love fear it may be lost; those in search of love fear it may never be found.

### Mental Hygiene: Its Limitations

Now there can be no question but that a mental hygiene which would help prevent mental illness would be useful to mankind. After that would come the greater task, the prevention of the growth of ubiquitous pathological character-traits which, because they are historically and biologically determined, are harder to uproot and cause greater unhappiness than all the symptomatic mental disorders put together.

Impulsive and compulsive behavior; stubbornness; reactive aggression that flows from internal and external frustrations; and most decisively, the emotional shallowness that robs the individual of the capacity to give or receive love—these traits of character show poor response to mass educational methods.

The mentally sick person is merely asocial and a trial to the immediate environment; pathological characters are unsocial or anti-social and, placed in position of power and trust, are a menace to millions. (Students of political psychology will recall many prototypes including some right here at home.)

An interesting hypothetical question arises: Would a successful program of prevention stop at the optimum point so that no harm would come out of it?

The chances are it would not be able to, so that a time would come when prophylaxis would be addressed to problems people did not know they had.

Mental hygiene measures that would deprive mankind of its insecurity will also remove the incentive to achievement, and we will find that we have thrown out the baby with the bath. Much of the great literature, painting, music and inventiveness, many great religious and ethical movements, are the products of the neurotically insecure mind.

Perfect mental health would leave humanity emotionally sterile. To take away man's ambivalency—the capacity to hate as well as to love, to experience pain as well as pleasure, to be aggressive and also passive, to know the nearness of death as well as the fullness of life, to swing from gloom to happiness or from good to evil—take away this polarity and the richness and excitement of life would also disappear.

Too much love can be as poisonous to humanity as too much hate. Thomas Moore has said it more poetically:

> But joy must often change
> its wing,
>
> And spring would be but
> gloomy weather,
>
> If we had nothing else
> but spring.

Since man is essentially an ambivalent creature, the prudent course is to teach him how to manage the peculiar contradictions of his personality, how to use them constructively in order to obtain the deepest satisfactions from life.

There are plenty of targets for man's hate other than his fellowmen. A release for hostility can be had in the fight against ignorance, superstition, ugliness, stuffiness, bigotry, and prudishness; in the struggle against disease, poverty and crime, including the horrible crime of communism.

The mental hygiene movement is now more than forty years old, but insofar as the critical observer can see, endopsychic conflicts are as common as, probably more common than, they were in that era when there was less accent on emotional security.

Perhaps it is just as well that the individual resists the idea that he should be measured to fit a procrustean bed. For when the time comes that we are willing to accept social institutions that promise freedom from insecurity, all other freedoms will be gone, including the right to be sane or a little crazy.

These philosophical pearls are not meant to be the final word on mental hygiene. New insights and methods may change the outlook.

It can do no harm, meanwhile, to temper the over-enthusiasm of the believers in the omnipotence of mental hygiene. In concentrating energy and time (and money) on the hapless victim of dementia praecox, we may let the big prize get away—the inhibited pathological character who seeks in power the satisfaction that he cannot gain in mature, heterosexual love.

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# "PLATELET THROMBOSES" INVOLVING THE GASTROINTESTINAL TRACT

## Report of a Case

HAROLD CIVIN, M.D. AND HENRY C. GOTSHALK, M.D.
HONOLULU

IN 1925 Moschcowitz[1] described a case of widespread thomboses in the arteriolar bed of a sixteen year old girl who died following a vague illness. In 1936, Baehr, Klemperer and Schifrin[2] established these findings as a clinical and pathologic entity while reporting 4 cases. During the past ten years an increasing number of cases have been reported. The syndrome is best known under the name of thrombotic thrombocytopenic purpura.

The clinical manifestations of the disease vary considerably. There are usually vague non-localizing or abdominal symptoms over a short or long period of time. The full-blown picture usually shows leukocytosis with a left shift of the cells of the granulocytic series, hemolytic anemia, icterus, hematuria, and thrombocytopenia. The disease is progressively fatal. Many of the reported cases show a variety of neurological manifestations during illness. There is no racial predilection. A majority of the reported cases have occurred in females.

The gross pathologic signs consist principally of petechiae and ecchymoses. No signs whatsoever may be present.

The microscopic picture consists principally of widespread arteriolar and capillary thrombi composed supposedly of agglutinated platelets. Many or all organs may be affected.

Recently Comess and Oyamada[3] described such a case with uremia associated with malignant nephrosclerosis and acute pancreatitis. The case to be reported here also died in uremia.

There is an increasing number of cases which fail to show the clinical picture of thrombotic thrombocytopenic purpura, but which histologically show similar thromboses in more localized areas. The problem which these cases present is to determine whether these are incipient or abortive cases due to the same etiology, or whether they are different entities related only histologically to thrombotic thrombocytopenic purpura.

### Case Report



DR. CIVIN

A 36-year-old white man was admitted to The Queen's Hospital on February 19, 1951, because of lower abdominal pain.

One month before admission, patient had begun having generalized abdominal pain accompanied by flatulence and constipation. On occasions he was nauseated but did not vomit. With the onset of these symptoms, he had gone to see a physician who studied his complaints. During this period x-rays of the gall bladder, stomach and colon, including barium enema and proctoscopic examination, all were negative. Stool specimens were negative for occult blood and amoebae. The one positive finding was a persistent elevation of the white blood count which fluctuated between 14 and 20 thousand, with a differential count in which polys always predominated. His temperature varied from 99.2 to 99.6 F.

He had had scarlet fever at 5, which impaired his hearing, and he had worn a hearing aid since the age of 13. In 1946, he had a thyroid adenoma removed successfully with no recurrence. In 1949, because of upper abdominal distress, x-rays were made which disclosed a duodenal ulcer. This condition responded well to treatment and within a month all his pain and discomfort had disappeared.

In March of 1950, the patient began to complain of stiff, sore neck muscles and at the same time began having vague abdominal symptoms. He was tired all the time and was unable to do his work properly.

On admission to The Queen's Hospital, the patient was seen to be a well-nourished young man, complaining of pain in the lower abdomen. His temperature was 99.2 F. His ears showed otosclerosis. The eyes and eyegrounds were normal. The chest was of the emphysematous type; no rales were heard. The heart was normal in size, shape and position. No murmurs were heard. The blood pressure was 130/85. The abdomen was moderately obese and not distended. There was tenderness to deep palpation in the lower abdomen with rebound tenderness on the right; peristalses were normal. Cursory neurological examination was normal.

Laboratory findings on admission: Red blood count 4,100,000, with 12.5 grams of hemoglobin. White blood cells, 15,600 with differential of 70 per cent polys, 28

From the Department of Pathology—Queen's Hospital.
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[1] Moschcowitz, E.: An Acute Pleiochromic Anemia with Hyaline Thrombosis of the Terminal Arterioles and Capillaries, An Undescribed Disease, Arch. Int. Med. 36:89 (July) 1925.

[2] Baehr, G., Klemperer, P. and Schifrin, A.: An Acute Febrile Anemia and Thrombocytopenic Purpura With Diffuse Platelet Thrombosis of Capillaries and Arterioles, Tr. A.A.M. Physicians 51:43, 1936.

[3] Comess, O. H., and Oyamada, A.: Uremia and Disseminated Platelet Cell (Thrombocyte) Thrombosis, Arch. Int. Med. 89:802 (May) 1952.

per cent lymphocytes. The urine was normal, and its specific gravity was 1.020.

The admission diagnosis was subacute Meckel's diverticulitis or appendicitis. The possibility of polyarteritis nodosa was considered.

On February 20, 1951, under spinal anesthesia, the patient's abdomen was explored through a lower right rectus incision. The omentum had an unusual light yellow color. The stomach, small and large intestines, and gall bladder were normal. In the region of the peritoneal reflection between the bladder and rectum was a small, slightly inflamed peritoneal cyst, which was removed without incident. The appendix showed evidence of healed disease and was also removed. The abdomen was closed without drainage and the patient was returned to his room in good condition.

The patient did well until the third post operative day when his temperature rose to 102 F. (rectally) and his abdomen became distended. A Levine tube was inserted and gastric suction begun. The patient was passing gas and feces by rectum. X-ray of the abdomen made on February 24, 1952, showed a distended small bowel. Peristalsis was present and there was no rigidity. Penicillin was discontinued and a Miller-Abbott tube was substituted for the Levine tube. This began to work well, but the patient in his delirium pulled it out several times. A Foley catheter was inserted.

On February 23 it was noted that his urinary output had diminished and in spite of adequate fluid and electrolyte maintenance his condition became worse. On February 25 the patient developed Cheyne-Stokes respiration and his urinary output became meager. The following day he became anuric. He was given oxygen by mask and Coramine intravenously, all without improvement. The patient expired on February 27 after being delirious for thirty-six hours. It is regrettable that during life no platelet count was made.

At autopsy the skin was a mixed red and purple color and showed hemorrhagic areas at the sites of multiple venous punctures. The right lung weighed 640 gms., with edema of the lower lobe and with marked congestion and partial atelectasis. The left weighed 580 gms., and was similar to the right. The pericardium was smooth, with no adhesions, and contained 100 c.c. clear fluid.

The heart weighed 360 gms. The endocardium was normal. The coronary arteries showed moderate sclerosis, but no evidence of occlusion. Atheromatous plaques were present in the aorta. The valves were normal.

The peritoneum showed no fluid or exudate. There was an area of congestion deep in the rectovesical fossa adjacent to the rectum. The area of the appendix revealed numerous petechial hemorrhages, and the appendiceal mesentery was congested.

The omentum was thickened and indurated in the region of the right lower quadrant. It had a peculiar light yellow color. The mesentery revealed numerous tiny, elevated, fatty tissues that resembled blisters, although there was no evidence of cyst formation. These were present along the entire mesentery adjacent to the small bowel. The lymph nodes appeared normal in size.

The stomach was congested. The duodenum showed a dimpling 2 cm. below the pylorus which probably represented a healing duodenal ulcer.

The jejunum and the ileum showed nothing unusual.

The colon had a mucosal ulceration 5 cm. in diameter in the distal sigmoid and a similar ulceration in the upper rectum.

The liver weighed 2800 gms. The outer surface revealed a nutmeg appearance with alternating yellow and red blotches.

The gall bladder and the pancreas were normal.

The spleen weighed 280 gms. It had a fibrous band around its mid-portion. The cut surface was markedly congested.

The right kidney weighed 170 gms. and the left 140 gms. The cortex of both kidneys measured 5 mm. The glomeruli were obscure and pyramids were edematous.

The pelvis and the ureters were normal.

The adrenals and the prostate were normal.

The bladder contained no urine. Its mucosa was congested and hemorrhagic.

The brain weighed 1230 gms. and showed no gross abnormality.

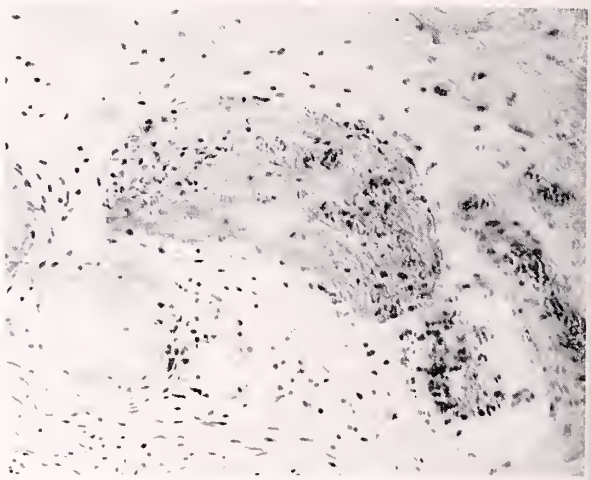


Fig. 1. Pale-staining acidophilic thrombi in a large arteriole (x 265).

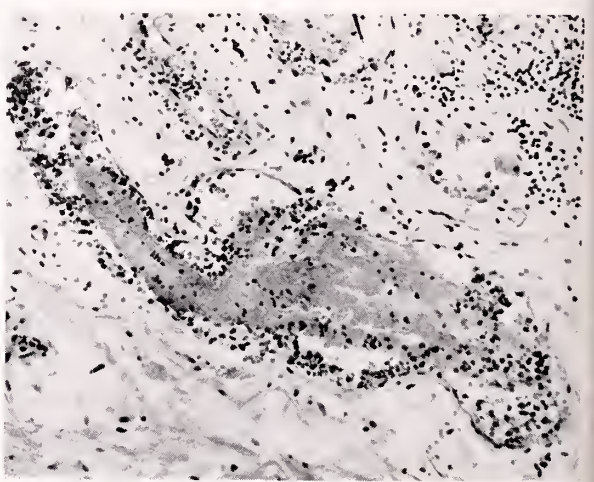


Fig. 2. Aneurysmal outpouching of the arteriolar wall (x 265).

The microscopic examination showed the arteriolar and capillary bed of colon, lungs, pancreas, liver, spleen, and small intestine revealed pale-staining acidophilic thrombi in varying numbers (Fig. 1). These were chiefly non-occlusive and were numerous only in the colon. The material resembled fibrin, platelets, or red cells. Van Gieson, McManus periodic acid–Schiff,

and Weigert's stain for fibrin all indicated this material to be negative for red cells, collagen, and fibrin; characteristic of the staining reactions of platelets (thrombocytes). Vessels in some organs showed early subintimal hyaline deposits. A noticeable feature in the colon was the tendency for asymmetrical dilatation of the arteriolar walls (Fig. 2). An occasional cell-rich thrombus (endothelial?) was noted.

The colon showed one or two small ulcers, whose bases were infiltrated by lymphocytes and plasma cells. These bore no particular spatial relation to the platelet thrombi.

Other findings were a marked fatty metamorphosis of the liver and the picture of lower nephron (hemoglobinuric) nephrosis in the kidney. The pancreas showed the acinar dilatation seen with uremia. Some chronic pneumonitis was present.

## Discussion

Until recently the clinical picture produced by the so-called "platelet" thrombosis syndrome has been considered as adhering to variable but somewhat narrow limits. Recent work has indicated that the pathologic picture may vary in degree and that the clinical expressions may also be variable.

Biegelman[4] has reported "platelet thrombi" in clinical syndromes resembling lupus erythematosus and in other so-called "collagen disease" symptom complexes.

Jones and Loring[5] in a study of 2293 necropsies showed 82 cases in which acidophilic thrombi were found in glomerular capillaries, and, in 24 of 30 cases in which the entire necropsy material was studied, in other organs as well.

It has come to the attention of the authors that Moschcowitz[6] has seen lesions like those in the colon in this case, in cases of ulcerative colitis. Stetson[7] has found platelet-leukocyte thrombi in cases of rheumatic fever.

The essential changes in the present case, as far as arterioles and capillaries were concerned, ranged from subintimally hyalinized walls through aneurysmal formations and acidophilic granular and amorphous thrombus formation (see figures), to endothelial-rich, completely non-occlusive thrombi. The lesions were chiefly seen in the colon. No specific etiologic agent can be held to account for the picture in the colon as far as our experience and study go.

The thrombi seen in the arterioles and capillaries were considered to be platelets by Baehr, et al. Gore[8] more recently has stressed the idea that the essential lesion is necrosis of the vessel wall upon which platelet material was deposited. Orbison's feeling[9] is that the vessel walls develop aneurysmal formations. Orbison further feels that the exact nature of the occlusive material is unproved since there is no histologic method of demonstrating platelets. For this statement the authors can find no refutation in the literature.

In the patient discussed here, the abdominal symptomatology may have actually constituted the prodromal stage of a more severe symptom complex. Also the disease may have been a factor in the ileus which apparently was a precursor of the lower nephron nephrosis.

In view of Moschcowitz's statement to us that he has found lesions similar to those in this case in early chronic ulcerative colitis, the possibility that this may have been an incipient lesion of this sort cannot be ruled out. This case showed none of the cryptitis or vasculitis described by Sommers and Warren.[10] In the present case minimal lesions were found in other parts of the body beside the colon, but these may have been coincidental accumulations of platelet material and hyalinization subintimally. The conclusion may be indicated that so-called platelet thrombosis may be a non-specific response to a variety of etiological agents. The work of both Biegelman[4] and Stetson[7] ties the phenomenon to hypersensitivity syndromes. It must be stated the common pathologic findings varying in degree do not indicate an identical etiologic agent varying in its intensity.

## Summary

A case presenting persistent unexplained abdominal complaints is reported. At necropsy hyaline and granular acidophilic thrombi were found in small vessels. It is felt that the pathological changes may have caused the symptoms and influenced the termination. The clinical and pathologic symptom complexes have been seen in the initial stage of thrombotic thrombocytopenic purpura, chronic ulcerative colitis, and a number of hypersensitivity or suspected hypersensitivity states.

[4] Biegelman, P. M.: Variants of the Platelet Thrombosis Syndrome and Their Relationship to Disseminated Lupus, A.M.A. Arch. Path. 51:213 (Feb.) 1951.

[5] Jones, D. P. and Loring, W.: Glomerular Thrombosis, Am. J. Path. 27:841 (Sept.-Oct.) 1951.

[6] Moschcowitz, E.: Personal communication to the authors.

[7] Stetson, C. A.: Studies On the Mechanism of the Shwartzman Phenomenon; Certain Factors Involving the Development of Local Hemorrhagic Necrosis, J. Exp. Med. 93:489 (May) 1951.

[8] Gore, I.: Disseminated Arteriolar and Capillary Platelet Thrombosis (A Morphological Study of Its Histogenesis) Am. J. Path. 26: 155 (Jan.) 1950.

[9] Orbison, J. L.: Morphology of Thrombotic Thrombocytic Purpura With Demonstrations of Aneurysms, Am. J. Path. 28:129 (Jan.-Feb.) 1952.

[10] Sommers, S. C. and Warren, S.: Pathogenesis of Chronic Ulcerative Colitis, Am. J. Path. 25:657 (July) 1949.

(H.C.) Queen's Hospital.
(H.C.G.) Young Hotel Building.



# The President's Page

The Mabel Smyth Building is a symbol of the sincerity, devotion to duty, tireless efforts in the interest of humanity, and the strength of character of Mabel L. Smyth, R.N. It is an appropriate monument to the memory of a splendid person who added brilliance to the history of nursing in the Territory of Hawaii and who by her deep love for her fellow men kindled the spark of Aloha in the hearts of her colleagues and the people with whom and for whom she worked.

The Mabel Smyth Building was an idea conceived by the Nurses' Association of the Territory of Hawaii and carried to a successful conclusion in January, 1941.

Many physicians, many individual citizens and many organizations from all Hawaii contributed to the building fund, but the nurses of the Nurses' Association of the Territory of Hawaii contributed the greatest proportion to the fund for this worthwhile project.

There were two organizations who guaranteed the maintenance of this memorial building to be used to house the nursing and medical activities of Hawaii. These guaranteeing organizations were the Nurses' Association and the Hawaii Medical Association.

Queen's Hospital owns the land and the building reverts to the hospital should it not be used for the purposes for which it was constructed. The Honolulu County Medical Society uses the building for its many activities including the maintenance of the Honolulu County Medical Library.

Since the territorial scope of utilization of the building is extremely limited in comparison to the utilization made by the Honolulu County Medical Society it seems to me that the Hawaii Medical Association should retire as a guaranteeing party in favor of the Honolulu County Medical Society. A glimpse into the future seems to reveal the fact that other component societies are developing their own county libraries and places of assembly. The physical location on Oahu of this building has naturally made it impossible for neighbor counties to utilize it for their county medical affairs, and I see no reason why they should continue to share the responsibility for guaranteeing the maintenance of the Mabel L. Smyth Memorial Building, beyond paying their pro rata share for use of the building. What do you think?

R. K. Brungardt, M.D.

Hawaii
MEDICAL JOURNAL

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# [EDITORIALS]

## RESEARCH IN HAWAII

Hawaii probably offers one of the best human laboratories in the world. This has been true in many fields, and an article by Theodore R. Rhea elsewhere in this issue emphasizes the point again.

Mr. Rhea's study indicates that death from cancer of the stomach is more frequent among Japanese men than men of other races. The significance of this to the whole field of cancer control would be tremendous if further study could be made to verify the accuracy of the basic statistical material and determine other racial differences and the causes for them.

Living in the islands are relatively large ethnic groups, mainly representative of countries bordering on the Pacific but including Puerto Ricans, Portuguese, Northern Europeans and Americans as well. These groups can be studied in Hawaii under almost ideal conditions. It is impossible in most instances to study the incidence of cancer in their homelands due to the inadequacy of reporting and population data. (It would be almost impossible, for example, to study the incidence of cancer with any degree of accuracy in the Philippines, China, Korea or even Japan.)

Not only do we have these various groups, but we have them in varying stages of development. For example, the Japanese in Hawaii are in transition from a foreign-born to a Hawaiian-born population. The large percentage of the Japanese population in the cancer age bracket now is foreign born. The Hawaiian-born are just beginning to move into this age bracket, and will predominate in it in another 20 years. What will be the situation then? What effect will changes in diet and other habits have on such a problem as cancer of the stomach?

Now is a strategic time to start a long-term research program in Hawaii to study the incidence of cancer in various ethnic groups, with special consideration of the effect of changing environmental influences.

## EMOTIONAL REACTIONS TO MASTECTOMY

The severe emotional impact of mastectomy is described in detail by Morton Bard, a psychologist at Memorial Hospital in New York, in a recent issue of *Public Health Reports*.[1] He offers sensible, practical advice for mitigating it.

He discusses the anticipatory anxiety aroused by the patient's first suspicions, the mounting dread as her suspicions become intensified, and the sharp focussing of these fears when the diagnosis is made. The usual state of mind on admission to the hospital for surgery, he states, is one of downright panic. Anticipations of anesthesia and of surgery both contribute to this emotional state.

Postoperatively, fears of social inacceptability predominate, and may be aggravated severely for some patients if family and friends obviously avoid any allusion to the operation in the patient's presence. Feelings of self-rejection may develop, and fears of rejection by the husband by reason of the emotional impact the mutilation may have upon him. Dread of ultimate loss of the remaining breast may contribute importantly to this depression.

Age, so often thought of as mitigating the severity of the emotional impact of mastectomy, is far less important, Bard points out, than the patient's own particular character defenses disrupted by the operation. An elderly patient may stand

[1] Bard, M.: The Sequence of Emotional Reactions in Radical Mastectomy Patients, Pub. Health Rep. 67:1144 (Nov.) 1952.

the operation—emotionally—far less well than a young one.

Bard urgently recommends continuing, understanding, sympathetic support, encouraging the patient to express her fears. Dependency in this regard is normal in the early postoperative period and should be encouraged, because it is usually temporary. Even anger and resentment should be expressed freely and openly at the beginning. Depression and self-pity are normal, too, and the patient should be told that this is so. Only if these reactions begin to form a stable, continuing pattern, that threatens to become permanent, should they be regarded as undesirable and combatted, he believes.

Mastectomy brings serious emotional problems with it—and the competent surgeon will keep this clearly in mind.

## EXCERPTA MEDICA, SECTION XVI: *CANCER*

This 94-page first issue of *Excerpta Medica's* Section XVI, just published this last summer, contains over 400 quarter-page abstracts of current articles on cancer, all written and signed by practicing specialists in this field, as is the custom of this excellent abstract journal.

Moreover, the articles are arranged under such selective headings as Radiotherapy, Alimentary system, Skin, Epidemiology, and so forth, so that a physician interested in a particular field of cancer literature can review it rapidly. The medical literature of the world is pretty thoroughly covered; we had no difficulty in finding a reference to a Russian journal in this issue.

The physician seriously interested in any aspect of cancer can scarcely afford, at only $10 a year, to neglect this opportunity to keep abreast of what is being written on the subject, the world over. Without such assistance, of course, he can hardly hope to keep even with the American literature alone.

## WHAT'S IN A NAME?

The United States Air Force and United States Navy Air University School of Aviation Medicine recently published a report entitled "Further Evaluation of Drugs for the Prevention of Sea Sickness."

Tested on Navy transports, and found *effective* in preventing seasickness, were:

| | |
|---|---|
| Lergigan | Wellcome 47-83 |
| Phenergan | Schering 1667 |
| Trimeton | Multergan |
| Benadryl | Parke-Davis S-45 |
| Parsidol | Trimeton-scopolamine |
| Pyrrolazote | Postafene |

Tested and found *ineffective* were:

| | |
|---|---|
| Lisergan | Dramamine |
| Probanthine | Mosidal |
| Isophenergan | Banthine |
| Bental | Dibenzylene |
| Diparcol | Buscopan |

Of the names we can recognize in these lists, then, the best remedies for seasickness are Trimeton, Benadryl, Phenergan and Pyrrolazote—and Dramamine and Banthine are not in the running.

What's in a name? Not a great deal, apparently.

## TOBACCO WITHOUT TEARS

Lung cancer is commoner than it used to be—but we don't know yet how much commoner it really is, and we don't know whether cigarette smoking is a really important etiologic factor or not—or, if it is important, how important it is. So says British roentgenologist D. W. Smithers in a recent issue of the *British Medical Journal*.[1] He deplores the excitement about cigarette smoking as premature, and points out that it is not paralleled by anything like comparable excitement over the smoking chimneys of our industrial centers—just for example.

Tabulations by J. A. Heady and R. G. Barley (of whom, they state, "50% is a smoker"!) in an earlier issue of the same journal[2] indicate, interestingly, that moderate smoking (by a man aged 25) raises his risk of dying of lung cancer before age 55 from 2 chances in 1000 to 32, and heavy smoking (2 packs or more daily) raises it to 54. His chance of dying from *other* causes before this age is *reduced* slightly, however!

A reassuring interpretation is given these latter figures by P. G. Moore.[3] He reassembled them graphically and computed the following table from them:

*Expectation of Life of a Man aged 25*

| | |
|---|---|
| Non-smoker | 45.9 years |
| Smoking 15-25 cigarettes per day | 44.9 years |
| Smoking 25-50 cigarettes per day | 44.2 years |

Thus, Dr. Moore points out, moderate smoking may reduce this young man's life expectancy by about 2.2% and heavy smoking may reduce it by about 3.7%.

Could I bum a cigarette from you? I just ran out.

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[1] Smithers, D. W.: Facts and Fancies about Cancer of the Lung, British Med. J. 4822:1235 (June 6) 1953.

[2] Heady, J. A., and Barley, R. G.: Smoking and Cancer of the Lung (Correspondence), British Med. J. 4819:1105 (May 16) 1953.

[3] Moore, P. G.: Smoking and Cancer of the Lung (Correspondence), British Med. J. 4822:1281 (June 6) 1953.

# THIS IS WHAT'S NEW!

S. Raffel, Professor of Bacteriology at Stanford, will soon report that **virulent tubercle bacilli utilize oxygen better** than non-virulent tubercle bacilli. In vitro tests indicate that the virulent organisms tolerate low oxygen tension better than the avirulent strains. B.C.G. behaves much like the virulent strains in regard to oxygen utilization. In vivo studies with oxygen concentrations varying from 14 to 50 per cent are under way. Ingenious plastic capsules are loaded with tubercle bacilli and temporarily sealed with a semipermeable diaphragm. This permits nutrients to get to the tubercle bacilli but keeps the bacilli confined to the capsule. The bacilli will grow even in "immune" animals where humoral but not cellular antibodies will penetrate the diaphragm. The capsule is loaded and dropped into the peritoneal cavity, then removed at any time desired.

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E. Jawetz, Professor of Microbiology at the University of California, compared skiing in the Alps to that in the Sierras, as well as comparing the **efficacy of the newer antibiotics.** "Magnamycin—a good drug but still looking for a disease." Erythromycin, in regard to antibiotic synergism: antagonism is like that of aureomycin, in Group II. Erythromycin may be the drug of choice for intestinal amebiasis, but for long-term therapy for such a disease as subacute bacterial endocarditis, the results are almost 100 per cent poor. This is largely due to the fact that resistance develops in 3 to 10 days. Checking antibiotic synergism in vitro by exposing the offending organism to the simultaneous action of two antibiotics has in some cases been very helpful. As the list of antibiotics grows and as resistant strains of bacteria continue to appear, such double-sensitivity testing may be indicated more frequently.

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R. Schaffarzick, of the Stanford Pharmacology Department, finds **Dormison** (referred to as methylparafynol or more exactly "an unsaturated tertiary carbinol having the chemical designation of 3-methyl-pentyneol-3") **better for fits** than for sleeplessness. It is effective in supressing grand and petit mal seizures. On one gram a day, 2 of 6 patients developed 4 plus cephalin flocculation tests, however; and studies of rats' livers revealed loss of basophilic stippling. Further studies on the tertiary alcohols as anticonvulsants are under way.

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J. P. Biehl, Assistant Professor of Medicine, University of Cincinnati, reports that the incidence of **peripheral neuritis** appearing during **INH** therapy closely parallels the dose. If the drug is stopped as soon as burning or tingling of hands and feet appear, the neuritis is reversible. Evaluation of specific treatment of the more advanced neuritis is under way and will soon be reported.

, , ,

How would you treat a 35-year-old mother of two, who has uncomplicated **toxic goiter with no palpable nodules?** Answers by a surgeon, an internist, a radiologist and a clinical pathologist were the same—namely, **radio iodine.** All had either treated, or had seen patients treated, by this method. All were aware of the fact that in general the present literature advised radio iodine for the older age group, poor risk, recurrent hyperthyroidism, etc. The hardest-to-answer argument against the use of radio iodine is the possibility of late malignant changes as a result of radiation. Thus far, after a decade of this form of therapy, no reports of cancer of the thyroid following radio iodine therapy have appeared.

, , ,

J. Luetscher, in discussing a patient with cirrhosis and edema, reviewed the progress of the Stanford Group in studying edematous patients, particularly with the **nephrotic syndrome.** These patients have large amounts of a sodium-retaining substance in their urine, which is probably a **mineralocorticoid**—not cortisone, and probably not one of the known corticosteroids. It is also found in the urine in increased amounts in normal men on a low-sodium diet. Although this substance decreases in amount (activity demonstrated by bioassay) during diuresis following ACTH or cortisone, nothing has been found to consistently decrease its activity, and precisely where it fits in the cause and effect pattern is unknown.

FRED I. GILBERT, JR., M.D

# BOOK REVIEWS

## Operative Surgery.

By Guy W. Horsley, B.S., M.D., F.A.C.S. and Isaac A. Bigger, M.D., F.A.C.S., Sixth Edition, Volume I and II, 1579 pp., illustrated, Price $30.00, C. V. Mosby Company, 1953.

This old favorite has been rewritten and brought up to date. Many texts on operative surgery immediately discuss technical steps but this work usually describes the condition one is treating in a brief manner first. The drawings illustrating the operations are excellent. Where several operations are in common use the one which the authors have used with most success is illustrated, the others being merely mentioned. There are many new sections in this edition. Some of these are the sections on varicose veins, principles of plastic surgery and skin grafting, thoracic surgery, etc. One new departure is including a section on gynecological surgery. "The authors believe that there is danger in too high a degree of specialization . . . and . . . it seemed advisable to include a description of the commonly employed gynecological operations, for a large majority of such operations are performed by general surgeons." This is a valuable reference book and text and a worthwhile set for the library of general practitioners and surgeons alike.

DEAN M. WALKER, M.D.

## The Ballistocardiogram.

By John R. Braunstein, M.D., Ph.D., 84 pp., illustrated, Price $3.00, Charles C. Thomas, 1953.

This little book is a brief, scholarly discussion of progress in ballistocardiography made during the past ten years, as well as a short historical summary. There is a discussion of the physical principles of vibrating systems, the mathematics of which become quite complicated. It would seem to be the opinion of the author that the ballistocardiogram is useful, particularly in coronary artery sclerosis, and that an abnormal ballistic pattern in an otherwise normal patient is a bad long-term prognostic finding. The author readily admits, however, that much more experience is needed in evaluating this instrument before it will find its eventual place in clinical medicine.

ALFRED S. HARTWELL, M.D.

## Visual Anatomy: Thorax and Abdomen.

By Sydney M. Friedman, M.D., Ph.D., 203 pp., illustrated, Price $10.50, Charles C. Thomas, 1952.

This is an excellent book for quick review of gross anatomy of thorax and abdomen. The line drawings by the author are very clear and not complicated by too much detail.

The best feature of this book is that each diagram is supplied with a facing page of text which explains completely the anatomical drawing.

This book is recommended for all surgeons as a quick reference of gross anatomy of thorax and abdomen. This is a visual text, the facts are presented largely by illustration.

K. M. AMLIN, M.D.

## Excerpta Medica, Section XVI: Cancer.

Excerpta Medica, Amsterdam, Volume I, No. 1, July, 1953, Price $10.00 per year.

The average physician finds it frustrating and actually impossible to keep up on the current medical literature. The publishers of *Excerpta Medica* have endeavored to alleviate this condition by abstracting the literature in special fields. The July, 1953, issue of this publication is devoted to cancer (experimental and clinical), and a cancer section will be published monthly henceforth. One cannot read this publication without being impressed first, with the vast amount of cancer research which is going on, and second, with the caliber of the men who are doing it.

Since this copy of *Excerpta Medica* contains abstracts from some 424 scientific reports, I will not try to review any specific report but will make general statements which apply to groups of reports abstracted.

In the field of cancer diagnosis, much has been accomplished through development of the cytologic technic as applied to various parts of the body. Because of the work in cytology, biopsies have been taken at earlier stages of the disease in many more cancers than was the case before the institution of cytologic procedures. The fields in which cytologic technics have contributed the most are cancers of the cervix uteri, and the respiratory system. The search still goes on for better technics for applying cytologic methods in the early diagnosis of gastric and urinary cancers. There is a spark of hope that a reliable serologic test for cancer may be turned up soon, but none thus far discovered can qualify.

One of the reports mentioned in this publication emphasizes the point that too much thought is given in cancer treatment to the artificial destruction of the cancer cell, either by surgical removal or other destructive methods. "Not enough attention has been paid to biological control by the host and the author goes so far as to predict that this will be the solution to the problem (biological control) . . . We should develop a better understanding of the host-tumor interrelation, an understanding that must precede any biologically planned attack on the cancer problem."

WALTER B. QUISENBERRY, M.D.

## Atlas of Regional Dermatology.

By Ernest K. Stratton, P.D., M.D., 274 pp., illustrated, Price $15.00, Charles C. Thomas, 1953.

This atlas is a useful addition to dermatologic literature. The author is to be commended for gathering together nearly 600 excellent illustrations and arranging them in regional groupings. This arrangement will aid the student and broaden the vision of the practitioner.

While excellent from the illustrative point of view, the book could be materially improved by further editing.

In addition to the "Atlas of *Regional* Dermatology," the book contains brief but good sections by Harry Arnold, Jr., on leprosy and by Maurice Costello on the acute infectious diseases.

SAMUEL D. ALLISON, M.D.

### Inhalation Therapy and Resuscitation.

By Meyer Saklad, M.D., 343 pp., illustrated, Price $7.50, Charles C. Thomas, 1953.

In my opinion this monograph represents the most complete review of the subject available in a single readable volume. The author has effectively integrated the knowledge gleaned from 402 references as well as his own clinical experience as one of our foremost anesthesiologists. It should be of interest to note that half of the book is devoted to developing in the reader a sound basis for analysis of physiologic and pathologic changes leading to or deriving from oxygen want; and an exposition of the symptomatology of hypoxia, the effects of inhalation of oxygen and the indications for inhalation therapy. The latter half of the treatise is a study of methods of treatment and resuscitation with ample discussion of the advantages and shortcomings of the many methods and apparatuses available today.

The monograph should be of interest and value to all physicians concerned with prescribing inhalation therapy or applying resuscitative measures. It should certainly be studied by all individuals responsible for the purchase of equipment to be used in hospitals, clinics, ambulances and emergency stations.

CARL E. JOHNSON, JR., M.D.

### Slipped Capital Femoral Epiphysis.

By Armin Klein, M.D., Robert J. Joplin, M.D., John A. Reidy, M.D. and Joseph Hanelin, M.D., 130 pp., illustrated, Price $6.75, Charles C. Thomas, 1953.

The above authors have collected a most interesting series of normal hips to show the bony development from the time of birth through the completion of epiphyseal growth and have also collected a series of minimal slipped epiphyses and pointed out the essential features and importance of diagnosis of minimal slipping. The results of simple nailing following minimal slipping of the epiphysis, as is generally known, are excellent, and this book will help as a reference book in early diagnosis. Unfortunately, there is much discussion as to the best method of treatment of the advanced slipping, and the above authors categorically imply that the method of treatment is almost infallible and imply that the treatment of slipped epiphyses of moderate to advanced degrees is not a particularly difficult problem. This is an unfortunate impression to present in a book of this type, and the book would have been better written without including their chapter on treatment.

IVAR J. LARSEN, M.D.

### Antibiotic Therapy.

By Henry Welch, Ph.D., and Charles N. Lewis, M.D. Foreword by Chester S. Keefer, M.D. 562 pp. Price $10.00, The Arundel Press, 1951.

An encyclopedic reference work, complete, authoritative, well worth owning even today, two years after publication.* Clear print, good paper and attractive format make it a pleasure to refer to it.

The seven major antibiotics (as of 1950) are discussed individually, followed by over 300 pages on individual diseases and their management with antibiotics. There is a good index.

HARRY L. ARNOLD, JR., M.D.

* Apologies to the authors and publisher are in order. This book was misplaced by the physician to whom it was originally submitted for review.—ED.

### Classics in Clinical Dermatology.

By Walter B. Shelley, M.D., Ph.D. and John T. Crissey, M.D., 467 pp., illustrated. Price 10.50, Charles C. Thomas, 1953.

This volume presents a biographical sketch and the original description of one hundred and forty-three separate disease entities described by ninety-five authors. It is carefully written, concise and accurate in every detail. It is amazing and enjoyable to read the clinical history of a disease presented over a hundred years ago. The type and format make for easy reading.

The book is worth the cost if one would read only the original description of Louis Duhring's Dermatitis Herpetiformis and Paul Unna's Seborrheic Dermatitis. No one has ever described these diseases so completely and distinctly. The volume was compiled for dermatologists primarily or students in dermatologic training. It is highly recommended.

HAROLD M. JOHNSON, M.D.

### Multiple Myeloma.

By I. Snapper, M.D., Louis B. Turner, M.D., and Howard L. Moscovitz, M.D., 168 pp., illustrated, Price $6.75, Grune & Stratton, Inc., 1953.

Multiple myeloma is not a disease frequently encountered in practice. It is natural that the average practitioner's knowledge of this entity is fragmentary at best. I found also during my management of one case that the literature on the subject was fragmentary.

Here summarized in one readable monograph is all fact and theory presently known about multiple myeloma. I. Snapper and colleagues also contribute whatever they have learned from observation of ninety-seven cases, of which forty-seven came to autopsy. Therapeutic trials with cortisone and ACTH are reported. This small book will be a great help to any one handling a patient with multiple myeloma.

M. E. STEVENS, M.D.

### The Psychopathic Delinquent and Criminal.

By George N. Thompson, M.D., 157 pp., illustrated, Price $4.50, Charles C. Thomas, 1953.

This little volume contains data of interest to professional workers in fields relating to guidance and handling of those individuals who chronically or severely breach the laws of the land. The author ascribes their difficulties to the interaction between their organically disturbed brain function and abnormal environmental factors. Neurological and electroencephalographic studies showed the incidence of abnormalities in a psychopathic group to be twice that of a control group. The incidence of various mental disorders in a number of types of crime was of interest, as were his suggestions as to therapy. Dr. Thompson's presentation was otherwise disappointing because of vagueness and lack of meaningful evidence to substantiate many of his statements. A number of important ramifications were left undiscussed and his statistics were at times confusing and contradictory. He frequently scoffed at "unvalidated psychoanalytic theories" of psychic influences on the genesis of the "true psychopath" while making only vague allusions to countering theories "based on known facts of cerebral physiology." This half-battle with psychoanalysis recurred frequently throughout the book without coming to any conclusion and was a detriment to the entire work.

JAMES G. HARRISON, JR., M.D.

### Differential Diagnosis of Common Diseases of the Eyeground.

By Paul Tower, M.D., 243 pp., illustrated, Price $10.00, Grune & Stratton, Inc., 1953.

This book of the diseases of the eyegrounds attempts to serve as a diagnostic text of the diseases of the retina. It is well written with short but complete descriptions of the retina. There are numerous photographs of the various diseases. It would have been better if there were an accompanying diagram illustrating the salient points in each photograph so as to be of some help to the reader in locating the characteristics of each disease. The text itself is not detailed enough to stand as a textbook on retinal diseases, although the bibliography is very complete. The photographs are in black and white and hence cannot convey the color differentiation which is important in retinal diseases. However, for those interested in a quick reference on this subject, this book is worth while having.

WAYNE W. WONG, M.D.

### Injuries of the Spinal Cord.

Edited by George C. Prather, M.D., F.A.C.S. and Frank H. Mayfield, M.D., F.A.C.S., 396 pp., illustrated, Price $8.75, Charles C. Thomas, 1953.

This book is the work of nine authors, each writing on the part his specialty can contribute to the care of patients with spinal cord injuries and the rehabilitation of paraplegics. Much of the work has been presented before but is here collected in one handy volume. The various aspects covered are neurosurgical, urological, nutritional, associated injuries and complications, decubitus ulcers, orthopedics, rehabilitation and psychological. All the authors had extensive experience in their fields during World War II so draw on an experience not to be obtained in civilian practice.

The volume is a handy size and the print large and easy to read. The orthopedic portion should appeal particularly to local readers because it was written by our late friend, Dr. R. Nelson Hatt.

JOHN J. LOWREY, M.D.

### New and Non-Official Remedies.

By the Council on Pharmacy and Chemistry of the American Medical Association, Robert T. Stormont, M.D., Secretary. 623 pp. J. B. Lippincott Company, 1953.

This annual list of products which the Council has accepted during the previous calendar year is, as usual, filled with useful information. All products listed are submitted voluntarily by their manufacturers, who must satisfy the Council's exacting requirements as regards manufacture, packaging, and claims. Council approval is necessary before such products can be advertised in A.M.A. publications or in those state medical journals obtaining advertising through the State Journal Advertising Bureau. This is occasionally the source of rather severe headaches for drug houses—but it is of inestimable value, of course, in protecting physicians and patients from the deluge of questionable preparations advertised in foreign (and less choosy U.S.) medical journals.

Get a copy for your desk—be sure you're using products good enough to ask for—and get—A.M.A. Council approval.

HARRY L. ARNOLD, JR., M.D.

### Roentgen Diagnosis of the Heart and Great Vessels.

By Erich Zdansky, M.D., translated by Linn J. Boyd, M.D., F.A.C.P., 500 pp., illustrated, Price $15.50, Grune & Stratton, Inc., 1953.

This first American edition of a classic German text should fill a definite place in the library of internists, cardiologists, thoracic surgeons, pediatricians, radiologists and all others interested in cardiovascular disease. The discussion of the heart and great vessels in both health and disease is comprehensive and excellent. Although the illustrations are not tonal reproductions of x-ray films this is not necessarily objectionable and is more than compensated for by numerous excellent line drawings and diagrams. An extensive bibliography up to the end of 1952, primarily of the German and American literature, is appended.

RICHARD D. MOORE, M.D.

### Arthritis and the Rheumatic Diseases.

By Philip Lewin, M.D., 175 pp., Price $3.50, McGraw-Hill Book Co., Inc., 1952.

This book was written primarily to give information to an intelligent layman concerning the arthritic diseases. It is particularly aimed at those laymen who may be afflicted with one of the various forms of the disease. Dr. Lewin is successful in presenting the many aspects of the various forms of arthritis in a very concise and yet fairly complete manner.

There are, however, a few criticisms which I would like to outline: (1) Only a very small percentage of patients in my particular practice would benefit from this text, because it is written for patients in a higher educational level than I usually see. (2) This book should not be recommended to any patient with a tendency towards neurosis. (3) I feel that the claims made for ACTH and cortisone may be slightly exaggerated. (4) Such phrases as "sluggish bowel elimination" at times make the text sound too non-professional. (5) The "low-salt" diet should be more detailed.

J. M. FELIX, M.D.

## Also Received

### The Surgical Clinics of North America.

August, 1953, Vascular Surgery—Surgery of Trauma, pp. 943-1226, figs. 266-332, $18 per clinic year, cloth binding; $15 per clinic year, paper binding, W. B. Saunders Company, 1953.

### It's Not All in Your Mind.

By H. J. Berglund, M.D. and H. L. Nichols, Jr., 343 pp., Price $3.95, North Castle Books, 1953.

For patients rather than doctors. An argument in favor of allergy as a cause of most "psychosomatic" ailments.

### Basic Problems in Psychiatry.

Edited by Joseph Wortis, M.D., 186 pp., Price $4.50, Grune & Stratton, Inc., 1953.

Just what the title says in 6 short essays and a summary.

### The Medical Clinics of North America.

September, 1953—Boston Number, pp. 1283-1593, figs. 170-205, $18 per clinic year, cloth binding; $15 per clinic year, paper binding, W. B. Saunders Company, 1953.

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The regular meeting of the Hawaii County Medical Society was held on Thursday, July 23, at the Hilo Memorial Hospital conference room.

Dr. Hayashi, president of the Society, called the meeting to order at 7:30 p.m. Present at the meeting were: Doctors Hayashi, Jenkin, Mitchel, Miyamoto, Mizuire, Okumoto, Ota, Stemmermann, Steuermann, and Woo.

Dr. Hayashi introduced the guest speaker for the evening, Dr. Harry Arnold, Jr., who gave a very interesting and enlightening talk on "Stress" as related to diseases in general and skin ailments in particular.

The meeting was adjourned at 9:30 p.m.

* * *

The regular meeting of the Hawaii County Medical Society was held on Thursday, August 27, at the Hilo Memorial Hospital conference room. The meeting was called to order by Dr. Hayashi, president of the Society, at 7:30 p.m.

A short movie on "Antibiotics and Terramycin" preceded the business meeting.

Present at the meeting were: Doctors Crawford, Hayashi, Loo, Miyamoto, Okumoto, Orenstein, Ota, Stemmermann, Steuermann, and Yuen. Dr. Hicking was the only guest present.

Dr. Irvin A. Rothrock's application for membership to the Hawaii County Medical Society was read to the members and this application will be submitted to the Board of Censors.

The following applications for participating physician with the Hawaii Medical Service Association were approved: Doctors Mitchel, Paynter, and Rothrock.

*Report on Council Meeting by Dr. Yuen:* The Council meeting was held at the Mabel Smyth Building on Thursday, August 6, 1953. Considerable discussion occurred on the rehabilitation problem.

*Communications Received:*

Mrs. Edith Bennett's letter pertaining to the recommendation of the Advisory Committee to the Bureau of Maternal and Child Health was read, which was followed by Dr. Nishijima's letter on the same subject. It was moved by Dr. Crawford and seconded by Dr. Okumoto that the secretary of the society notify the Advisory Committee to the Bureau of Maternal and Child Health that the members of the Hawaii County Medical Society would like to have the next annual meeting of the committee on our next regular monthly meeting at which time the recommendations of the committee will be discussed at length. In the meantime, the secretary will send mimeographed copies of the recommendations of the Committee to all the members of the Hawaii County Medical Society to acquaint them with the recommendations.

Mr. James Carroll's letter asking for the Society's "kokua" in promoting the Hawaii Medical Service Association's Plan V, Surgical-Hospital-Maternity benefits on individual basis was read. It was moved by Dr. Orenstein and seconded by Dr. Yuen that the members of the Hawaii County Medical Society will assure Mr. Carroll of our efforts to promote this plan.

Letter from Dr. Shoyei Yamauchi, Chairman of the Postgraduate Committee, regarding guest speakers for our scientific meetings was read. After a short discussion, it was moved by Dr. Steuermann and seconded by Dr. Miyamoto that the secretary arrange with the Postgraduate Committee of the Hawaii Medical Association and work out a program of having a postgraduate lecture every three months.

Meeting was adjourned at 9:30 p.m.

* * *

A scientific dinner meeting of the Hawaii County Medical Society was held on Thursday, September 3, 1953, at the Hilo Yacht Club. The following members were present: Drs. M. H. Chang, M. L. Chang, Crawford, Hata, Jenkin, Kasamoto, Knotts, Kutsunai, Leslie, Loo, Mitchel, Miyamoto, Mizuire, Okumoto, Ota, Stemmermann, Steuermann, Tomoguchi, Wong, Woo, Richard Yamanoha, and Yuen. Guests present were: Doctors Hicking and Rothrock.

Guest speaker for the evening was Dr. Ingersoll, Chief of Radiological Service of the Veterans Administration, Denver, Colorado. He gave a very interesting lecture on "Radiological Aspects of Adult Cardiac Disease," illustrated with numerous slides.

A brief discussion followed the lecture and the meeting was adjourned at 10:00 p.m.

NICHOLAS STEUERMANN, M.D.
*Secretary*

## HONOLULU COUNTY MEDICAL SOCIETY

Honolulu County Medical Society held its regular monthly meeting on Friday, September 4, at 8:00 p.m., with Dr. C. M. Burgess presiding and approximately 65 members and guests present.

Mr. V. E. Cannon, representative of Eli Lilly Company, discussed his company's newly developed drugs.

Dr. Samuel D. Allison presented a paper on Psychosomatic Dermatology Circa 1850. A lively repartee followed Dr. Allison's presentation.

Dr. William H. Stevens discussed a New Aspect of Therapy in Psychosomatic Diseases.

Dr. A. S. Hartwell reported on the AMA Convention, covering the highlights of controversial items taken up by the House of Delegates.

Dr. Izumi spoke on the progress of the Public Service Committee, namely the appointment of an executive secretary for the Honolulu County Medical Society. With a good public relations setup functioning, the Committee feels that it is a definite step toward improved doctor-patient relationship. The executive secretary will be charged with the responsibility of forming a collection and credit agency to support this program. The agency will be patterned after the Alameda County Association's plan which is known to be most successful from the public relations and financial angle.

The Public Service Committee feels that the proceeds earned from this arrangement will decrease the financial burden of operating the Society, although it does not necessarily mean a reduction in dues. Mr. Rollen Waterson, Executive Secretary of the Alameda Associa-

tion, has offered to train the Society's appointee in procedures pertaining to their public relations program and credit agency for Honolulu.

Discussion followed concerning the practice of continuing to depend upon the Cancer Society and allied organizations for postgraduate speakers. The Postgraduate Committee recommended that a general surgeon and an internist be invited to lecture.

Although the Board of Governors approved the Committee's suggestions and recommended a five dollar per capita assessment to defray the cost, the membership felt that it would not be necessary inasmuch as many prominent mainlanders are expected to participate in the Pan-Pacific and Oto-Ophthalmological meetings scheduled for November and April, 1954.

It was therefore recommended that the Postgraduate Committee be instructed to invite an internist for the Society's postgraduate lectures in 1954, and that the Committee be further instructed to seek the financial support of the Cancer Society.

Refreshments were served on the lanai following adjournment at 10:00 p.m.

* * *

The Society's regular membership meeting was held on Friday, October 2, at 8:00 p.m. in the Mabel Smyth Auditorium. Dr. William S. Ito presided with approximately 55 members and guests present.

An announcement of paramount interest to all was the recent appointment of Mr. Richard M. Kennedy as Executive Secretary of the Honolulu County Medical Society.

On behalf of the Society, the Board of Governors welcomed the following new members: Drs. Vernon G. Boido, Edward W. Boone, Ted W. S. Chong, Ellsworth B. Harris, James G. Harrison, Jr., Robert P. C. Ho, Elmer C. Johnson, Pershing S. Lo, Ernesto M. Santos, Daniel Whang and Dorothy Kemp.

*Program:*

Raudixin—Mr. Henry E. Petersen of Squibb Company.

World Health Organization—Dr. Richard K. C. Lee.

Medical Observations in Great Britain—Dr. W. B. Quisenberry.

Hawaiian Fish—Mr. Spencer Tinker of the Honolulu Aquarium.

Refreshments were served following adjournment at 10:15 p.m.

R. C. Durant, M.D.
*Secretary*

## KAUAI COUNTY MEDICAL SOCIETY

The regular meeting of the Kauai County Medical Society was held on August 11, 1953, at 7:40 p.m. in the G. N. Wilcox Hospital medical library. Dr. Ishii, president, presided. Members present were Drs. Kuhns, Wallis, Fujii, Masunaga, Kim, Wade, and Cockett. Guests present were Dr. Kemp and Dr. Strongman, resident.

Dr. Kemp presented a new form for the Fetal Waste Survey for consideration by the members. It was decided to defer final consideration until legal opinion regarding the form is obtained.

The Physician's Malpractice Liability Insurance as offered by the National Ben Franklin Insurance Company of Pittsburgh, Pennsylvania, was briefly discussed.

The physical examination forms for Y.M.C.A. campers, which suggest that the examination by the physician is gratis, were presented for discussion. It was moved, seconded, and unanimously approved to forward a communication to Mr. Homer Eng, Y.M.C.A. Executive Secretary, stating that it is the prerogative of the examining physician to decide whether or not to charge for his service.

*Communications:*

From Dr. Samuel Yee, Secretary of the Hawaii Medical Association, regarding the recommendations of the Advisory Committee to the Bureau of Maternal and Child Health, Emergency Nursing Guides for the Care of Premature Infants, Suggested Nursing Guides for the Maternity Patient in Premature Labor, and the recommendations of the Advisory Committee to the Bureau of Crippled Children. The aforementioned recommendations were read in toto by Dr. Ishii for consideration by the members. It was moved, seconded and unanimously approved to file the recommendations in the minutes.

From Dr. Richard K. C. Lee, President of the Board of Health, requesting the names of at least two members for consideration by Governor King in the appointment of a Kauai member to the Board of Medical Examiners. Dr. Ishii revealed that the complete roster of the Kauai County Medical Society was presented.

From Dr. Shoyei Yamauchi, Chairman of the Postgraduate Committee, regarding the continuation of the postgraduate sessions. Dr. Ishii appointed Dr. Cockett to arrange the postgraduate sessions this year.

Meeting adjourned at 9:10 p.m.

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The regular meeting of the Kauai County Medical Society was held on September 8, 1953, at the G. N. Wilcox Memorial Hospital medical library. The meeting was called to order by Dr. Ishii, president, at 7:45 p.m. Members present were Drs. Wade, Masunaga, Fujii, Cockett, Goodhue, and Yamauchi. Guests present were Dr. Kemp and Dr. Maxwell Boyd.

*Old Business:* Dr. Kemp expressed the opinion of the Territorial Attorney General regarding the Fetal Survey form that there is no legal danger involved and the suggestion that a release be included. Following a discussion, Dr. Goodhue moved that the Fetal Survey form be accepted for a trial period until January 1, 1954. This was seconded by Dr. Fujii and was approved. Six ayes and one member not voting.

*Communications:* From Homer Eng, Acting General Secretary, Y.M.C.A., regarding the form for physical examination of "Y" campers.

From Mr. Veltmann, General Manager, H.M.S.A., regarding some modifications of benefits providing greater assistance to the doctors and the membership.

From Dr. Satoru Nishijima, Chairman of the Advisory Committee to the Bureau of Maternal and Child Health, acknowledging the cooperation given to the Committee at the July meeting on Kauai.

The application for membership by Dr. Maxwell Boyd was presented to the members for consideration. Final consideration is pending.

Dr. Wade, member of the Board of Directors of the H.M.S.A., presented a brief report on the financial status of the organization.

There being no further business, meeting adjourned at 8:30 p.m.

Richard M. Yamauchi, M.D.
*Secretary*

## MAUI COUNTY MEDICAL SOCIETY

The regular meeting of the Maui County Medical Society was held on August 11, 1953, at the Kula Sanatorium. Those present were: Doctors Ferkany, Tompkins, Cole, Ohata, Rose, Shimokawa, Haywood, Tofukuji, Patterson, Underwood, Edward Kushi, Knox, Izumi, Burden, Wong and Harold Kushi. Guests included Doctors Mei and Lau.

After cocktails and dinner, the meeting was opened by President Tompkins.

Dr. Underwood brought in a request from the Maui County Cancer Society concerning the possibility of establishing a Cytological Laboratory on Maui. The Medical Society went on record as opposing the establishment of a Cytological Laboratory at the present time because the services rendered now by the Honolulu Laboratory are adequate.

A letter from Dr. Yamauchi was read in regard to the postgraduate program for Maui. He stated that speakers in various specialties were available whenever the Maui Society wish them to come over. The matter was turned over to Dr. Patterson of the program committee for future reference.

Dr. Ferkany gave a brief report of the Council Meeting he attended in Honolulu recently.

Dr. Ohata, Commission member from Maui serving on the Medical Indigent program, gave a brief report on the money available for this use for the biennium. He urged that patient hospital days be cut down to a minimum so that more people can be served by the reduced budget.

The secretary read the financial report of the Society and it was voted unanimously to make a special assessment of ten dollars per member to make up the deficit for the fiscal year 1953-54.

The balance of the meeting was turned over to Drs. Tompkins and Ferkany, who gave a most enlightening talk on the use of planography in the diagnosis and treatment of pulmonary diseases, especially tuberculosis. The talk was illustrated with case studies, x-rays and planograms.

The meeting was adjourned after the scientific program.

* * *

A special meeting of the Maui County Medical Society was held on Friday, September 25, 1953, with Vice-President Dr. Rockett presiding.

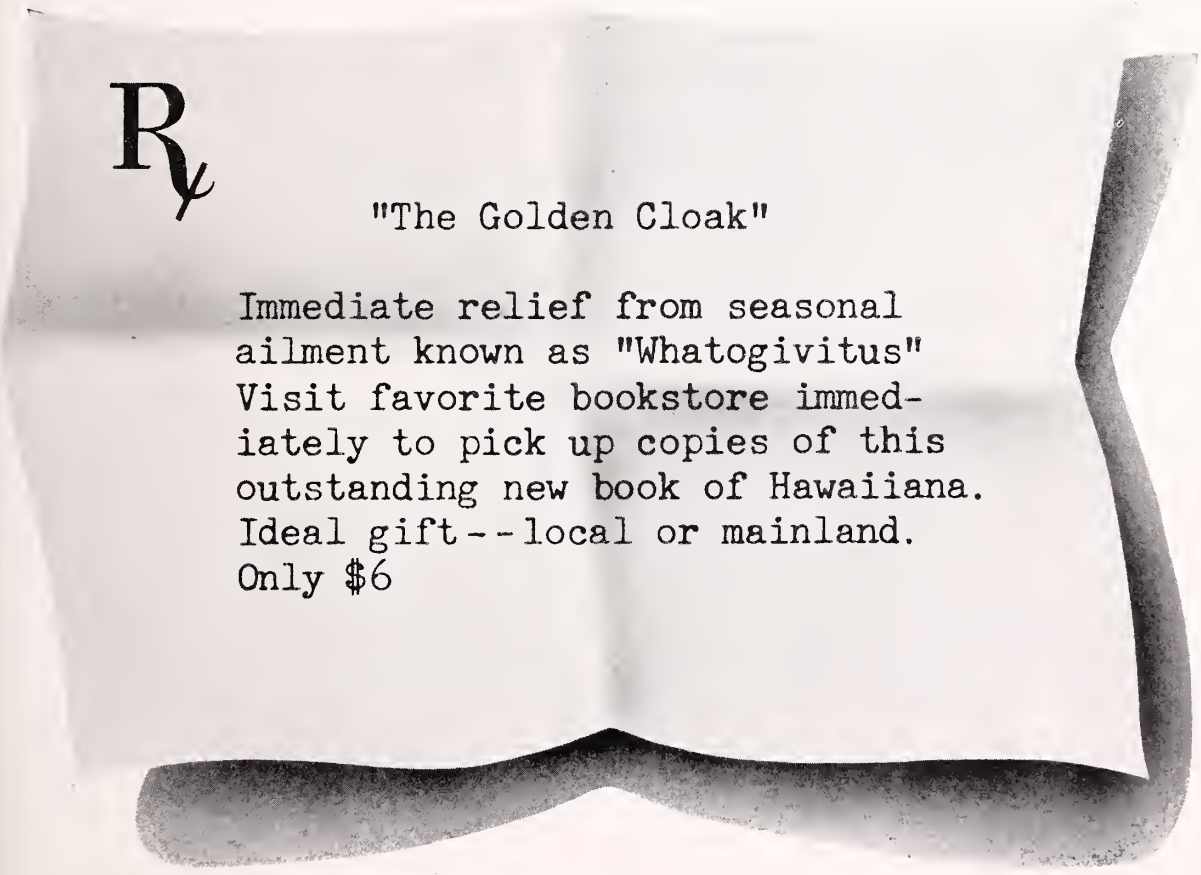
Members present were: Doctors Shimokawa, Kanda, Kashiwa, Underwood, Fleming, Wong, Izumi, Mei, Sanders and H. Kushi.

Guests present were: Dr. Richard Dodge and Mr. Jack Moriarty.

Dr. Dodge and Mr. Moriarty came from Honolulu and presented a resume of the establishment of the Rehabilitation Center in Honolulu. This talk was illustrated with a sound motion picture on the rehabilitation program as carried out by the federal government. The talk and the picture were enjoyed by all present and were enthusiastically received.

No business was transacted and the meeting was adjourned following the presentation.

HAROLD S. KUSHI, M.D.
*Secretary*



# HMSA—Its Place in the Community

## National Affiliations

J. R. VELTMANN, *General Manager*

Blue Shield Medical Care Plans, the National Association for voluntary prepayment medical plans, has been actively developing better coordination and closer liaison among the seventy-eight Blue Shield member Plans throughout the nation to serve the twenty-six million Blue Shield members better. As a member plan, HMSA is kept abreast of national trends and improvements in the voluntary prepayment plan movement through its affiliation with the National organization. Some of the methods applied to foster good relations among plans are:

1. *Financial, Membership and Statistical Reports.* Each month, certain statistical, financial and membership data are submitted to the Commission which are assembled and grouped by plans of similar size offering comparable data on financial status and membership growth of each plan. Statistical reports indicate trends in various types of services required by members. HMSA is proud to report that it compares very favorably to the national averages in all phases of operations, especially in membership gains and reserves.

2. *Literature and Publications.* For several years there has been a system of mutual exchange of literature and publications between Plans and by reviewing these publications, HMSA has incorporated many progressive ideas into its operations which in turn have afforded better service to its members.

3. *National Enrollment.* In order to properly service large industrial enterprises spread throughout the nation, the Blue Shield Commission established a separate corporation called Medical Indemnity of America, Inc., for the purpose of negotiating and underwriting uniform medical plans for such national accounts. When such a plan is written, MIAI will negotiate with each Blue Shield Plan individually to cover employees of the company in its area. HMSA is a participant of Medical Indemnity of America, Inc., and would cover employees of such National Accounts residing in the Territory of Hawaii. Through this program, the Blue Shield Plans would be in a position to offer its services to many accounts who have heretofore been covered by commercial insurance carriers.

*Inter-Plan Transfer.* The establishment of an Inter-Plan Transfer Agreement by the National Association is another great stride in the progress of Blue Shield. Under this Agreement, a Blue Shield member can retain the seniority gained in one plan whenever there is a change of residency. On request of the member, the Blue Shield Plan of the new locale will correspond with his "OUT" plan for all necessary data relative to membership and accept the member for their coverage with credit of membership with the former plan.

HMSA has been accepting transfers from all mainland Blue Shield and Blue Cross plans for several years as an added service, but our members who move to the mainland have not always been granted reciprocal transfer privileges. However, many of our members have retained our Surgical-Hospital protection because HMSA will reimburse for surgery performed away from the Territory of Hawaii on the same basis as it would pay for services rendered locally, and will reimburse for hospital services rendered up to the amount of $12.00 per day. With this new Agreement, HMSA members will enjoy the privilege of transfer to all other Blue Shield Plans who are participants of this Transfer Agreement.

*National Advertising.* The Blue Shield and Blue Cross Commissions are presently developing a national advertising program to promote voluntary prepayment medical plans for the mutual benefit of all plans throughout the nation. We look to our participating physicians as the greatest salesmen of HMSA and know that with their full support, HMSA will become a household word in Hawaii.

All of the efforts exerted by the National Association mean a great deal to the member and promote efficient functioning of all Blue Shield Plans. HMSA is proud to be a participant in this National movement.

# NOTES AND NEWS

## FRANCIS JOHN HALFORD, M.D.

### 1902 - 1953

I first met Dr. Halford in New York City in 1926. He was a young man full of enthusiasm and impressed me as a sparkling and keen doctor who was very anxious to do a real job in medicine. I was delighted to accept him for an interneship at The Queen's Hospital. He had just graduated from the University of Pennsylvania where he had made an excellent record. He came to Hawaii the same year and served his interneship of two years. During his service, he won the admiration of all by his constant fund of good humor, congeniality, enthusiasm, and also by his kindness to his associates as well as his patients. He was willing to give to the utmost to anyone who might need his help.

On August 29, 1929 he married Marjory Atherton. These two during the years formed a team which has been a great delight to all those who have had the privilege of knowing them. It was a pleasure to visit their home, for it gave one the feeling of beauty, congeniality, and the spirit of hearty welcome. Their four children are a real credit to them and reflect the environment of understanding parents.

He was a member of: Alpha Tau Omega, Phi Rho Sigma, Pacific Club, Outrigger Club, Central Union Church, Mason 32nd Degree, Shriners, Royal Order of Jesters, Social Science Club, and the Hawaiian Historical Society. These indicate a wide community interest.

In his profession he served repeatedly on hospital staffs. He was medical director of Kamehameha Schools, director of Honolulu Blood Bank, chief of the National Board of Medical Examiners for the Territory of Hawaii. He was on the Honolulu County Medical Library Board. In 1944 he was elected president of the Honolulu County Medical Society. Last year he was elected vice president of the Pan-Pacific Surgical Association. He had been active in that organization for years. He had taken a postgraduate trip to Europe and a postgraduate course in Industrial Medicine at Columbia. He contributed 12 articles to medical literature.

During the Pearl Harbor excitement of December 7, he threw his whole soul into helping. He received a citation from the Surgeon General and another commendation from the Commanding General, United States Army Forces, Pacific Ocean Areas.

He was one of the charter members of The Medical Group. There are few doctors who have earned as many friends as Dr. Halford. It can truly be said of him, "If you want a friend, be one." His hard-driving temperament was probably also his undoing. He was never satisfied with what he had accomplished, but always restless to be on to heights ahead. He developed a peptic ulcer which ruptured and for which surgery was necessary. Later, he developed a gastro-colic fistula which required extensive resection two years ago. However, he came back remarkably well. He never lost his genial, driving temperament. The night before his death, when he phoned his wife, he spoke very enthusiastically about his trip to Chicago and was looking forward to seeing his many friends there. However, he had been very deeply moved that day on visiting the Gerbodes, old friends whose son had recently been killed in an automobile accident. He reacted emotionally over tragedies of his friends to the point of severe suffering. His sudden death was from sclerosis of the anterior coronary artery.

He will be greatly missed by the whole community. For no matter what their differences of opinion might have been or their annoyances, people could not help but like his kindly, genial, and blithe personality. They admired his ability to bounce back no matter what the difficulties or problems had been.

The following poem of Don Blanding's, I think, describes Pete, as he was affectionately known by hundreds of friends:

"A man will know when he's chosen
By the Gods for a life of quest,
For the restless urge within him
Is an eagle in his breast.

"An eagle with frantic pinions
Which may not be caged or tamed,
With eyes on the far horizon
And becoming stars unnamed . . .

"Then, after the search is over,
After the finding . . . rest?
There is no rest for the seeker
With an eagle in his breast."

A quote from John L. Elliott also seems to have caught Pete's philosophy: "I have found that the only things worth living for, working for, and dying for, are friendship and love."

NILS P. LARSEN, M.D.

## PERSONALS

**Dr. Raymand deHay** and **Dr. Thomas Min** were recently certified by the American Board of Internal Medicine.

Gov. S. W. King appointed **Dr. Harry L. Arnold, Jr.,** as official Territorial delegate to the Sixth International Leprosy Congress in Madrid, Spain. The McInerny Foundation provided a grant to cover part of Dr. Arnold's expenses. **Dr. Harry L. Arnold, Sr.,** accompanied his son to this meeting.

**Dr. Joseph Palma** of the Straub Clinic and **Dr. Jahn P. Kametani** attended the meetings of the American Academy of Pediatrics in Miami, Florida, and the International Congress of Pediatrics in Havana, Cuba.

**Dr. Yautaik Kim,** formerly of Honolulu, has been appointed resident physician at Kalaupapa Settlement. Dr. Kim, a native of Korea, first arrived in Hawaii in 1905. He received his medical degree from Emory University in Atlanta, Georgia.

**Dr. Richard K. C. Lee,** President of the Territorial Board of Health, attended the Western Pacific Conference of the W.H.O. in Tokyo, Japan, in the capacity of advisor to the United States delegation.

**Dr. J. T. Lucas, Jr.,** announces his return from naval duty and the resumption of private practice at 145 Lehua Street, Wahiawa.

**Dr. William H. Wilkinsan** announces a change of office to 366 Kilani Avenue, Wahiawa.

**Drs. Harald Maffat, Ogden Pinkertan, Harald Kimata,** and **Philip Corboy** and **Cal. Austin Lawrey** attended the meetings of the American Academy of Ophthalmology and Otolaryngology. Dr. Corboy, as National Executive Committeeman from Hawaii, will also attend the meeting of the American Legion in St. Louis and return by way of Acapulco where he will participate in the annual Big Game and Fishing Contest held there each year.

**Dr. William Jahn Holmes** was elected to the membership of the Ophthalmological Society of the United Kingdom.

**Dr. Alma K. Leong** became the bride of Leon L. M. Chung on July 28, 1953. Dr. Leong received her premedical education at the University of California and received her M.D. at the University of Rochester School of Medicine. She interned and served one year as resident in Pediatrics at the University of Rochester and Strong Memorial Hospitals. Following this, she served an additional year at Children's Hospital in Los Angeles. Dr. Leong is limiting her practice to pediatrics with her office in the Occidental Building in association with **Dr. Edward C. Wa Lum.**

**Dr. W. T. Chack,** formerly of Hilo, announces the opening of his office with practice limited to pediatrics. Dr. Chock is a graduate of Loyola Medical School, Chicago, Illinois. He served a year's residency at St. Louis City Hospital and Cook County Hospital. He also served a three-year residency at Cook County Hospital, in pediatrics.

**Dr. Frank E. Glaser,** physician at South Shore Hospital, was married to Miss Nadine Cabell Witener of Pomona, California. Dr. and Mrs. Glaser spent their honeymoon at the Volcano House.

**Dr. Y. C. Yang,** a former Honolulu physician and at present Korean ambassador to the United States, spent a few days in Honolulu on his way to Korea from Washington, D.C.

**Dr. Corazan Manayan,** for the past two years resident physician at St. Francis Hospital, is now at St. Mary's Hospital in Minneapolis, Minn., as a resident in obstetrics and gynecology.

*New Babies Were Born To:*

**Dr. and Mrs. Laurence G. Thavin,** on October 2, 1953, a daughter, Michele. This is their fifth child.

**Dr. and Mrs. Wayne Wong,** on August 17, 1953, a son, Jan. This is their third child.

**Dr. and Mrs. Albert Ho,** on July 21, 1953, a son, Lawrence. This is their third child.

**Dr. and Mrs. William Walsh** are the proud parents of a daughter, Kathleen.

**Dr. William Cody** recently arrived in Honolulu to join the staff at the Territorial Hospital, Kaneohe. Dr. Cody is a graduate of Tufts Medical College, 1951. He interned and served for one year as resident in psychiatry at St. Elizabeth's Hospital, Washington, D.C.

Attending the meeting of the American College of Surgeons were **Drs. Harald Kimata, Peter Washko, Joseph Strode,** and **Samuel Yee.** Dr. Strode was invited to participate in the panel discussions of Gastric Ulcers. **Drs. Harry B. Allisan, K. S. Tam,** and **Verne C. Waite** were inducted as Fellows of the College at this meeting.

Back from mainland medical trips are **Drs. Thomas Cowan, Richard H. P. Sia, Howard Liljestrand, Kiyashi Inauye, L. A. Honl, Lester Yee, Marton Berk,** and **Fred Lam, Sr.**

**Dr. E. Wansik Yau,** chief of the anesthesia department at Queen's Hospital, accompanied by Mrs. You, left for the annual meeting of the American Society of Anesthesiologists in Seattle, Washington.

**Dr. Helen Wallace** will be in charge of anesthesia at Queen's Hospital in the absence of Dr. You. Dr. Wallace is a graduate of Oklahoma University Medical School. She interned at the Medical College of Virginia at Richmond. Following this, she served a two-year residency in anesthesiology at the Charity Hospital in New Orleans. Dr. Wallace is married to **Dr. Allen Oglesby** who, at the present time, is completing a residency in pediatrics at the Kauikeolani Children's Hospital. Dr. Oglesby is a graduate of the Medical College of Virginia. He served his internship at the Charity Hospital in New Orleans and following this spent one year in general practice in Mississippi.

**Drs. Phillip Arthur** and **Peter Washko** attended the meeting of the American Roentgen Ray Society in Cincinnati.

**Dr. Jahn W. Haward** was awarded the Commendation Ribbon with Combat Distinguishing Device by Rear Admiral S. S. Murray, Commandant of the 14th Naval District. Dr. Howard was chiefly responsible for over 1000 major operations aboard the hospital ship "Consolation" off Korea. At the present time, Dr. Howard is taking advanced training at Children's and Shriners' hospitals, Honolulu.

Gov. S. W. King has appointed the following men to the Territorial Board of Medical Examiners: **Dr. Douglas Bell,** Chairman; **Dr. I. L. Tilden,** Secretary; **Dr. Samuel Yee, Dr. Thomas Fujiwara, Dr. H. E. Crawford** of Hawaii, **Dr. Frank A. St. Sure, Jr.,** of Maui, and **Dr. William W. Gaadhue** of Kauai.

The Medical Group announces the addition of **Dr. Elmer C. Jahnson** to its staff. Dr. Johnson served a one-year internship at Queen's Hospital and one year at Hawaiian Pineapple Plantation, Lanai. He also served a three-year medical residency at Hines Veterans' Hospital, Illinois. Dr. Johnson is married and has three children.

**Dr. Ted W. S. Chong** announces the opening of his office at 346 Young Hotel Building. Dr. Chong is a graduate of the University of Pennsylvania, class of 1946. He interned at the Aiea Heights Naval Hospital. Following this, he had one year of advanced training in obstetrics and gynecology at the Graduate School of Medicine, University of Pennsylvania. In addition, he also spent three years in obstetrics and gynecology at Cooper Hospital, Camden, New Jersey. Dr. Chong is married and has two children.

**Dr. Edward T. Matsuoka** announces the opening of his office at 1230 South Beretania Street for the practice of obstetrics and gynecology. Dr. Matsuoka is a graduate of the Medical School of the University of Virginia, 1941. He interned and was surgical resident at Wayne County Hospital, Detroit. He received his specialty training at Women's Hospital, Detroit.

**Dr. William E. Stone** was recently appointed associate physician at the Ewa Plantation Hospital. Dr. Stone is a graduate of Louisiana University School of Medicine, class of 1949. He interned at the Charity Hospital, New Orleans. Following one year military service with the United States Air Force, Dr. Stone served a general practice residency at Charity Hospital, Lafayette, Louisiana.

**Dr. Laurence Wiig** returned from a mainland trip where he visited surgical centers in St. Louis, Indianapolis, Denver, and Reno. He also addressed the Reno Surgical Society on July 22, 1953, on "The Cancer Problem in Hawaii."

**Dr. Robert R. Johnson** has been named Assistant Medical Director at the Waialua Agriculture Company's Hospital. Dr. Johnson is a graduate of the University of Utah School of Medicine, class of 1951. He did postgraduate work and served a one-year internship at the Holy Cross Hospital, Salt Lake City.

Following his return from the annual convention of the Western Orthopedic Association in Sun Valley, Idaho, **Dr. J. Warren White** became affiliated with the Straub Clinic in the practice of orthopedic surgery. Dr. White is now president-elect of the Western Orthopedic Association as well as of the American Orthopedic Association.

## Hawaii

**Dr. Chisato Hayashi** of Kona and **Doctors Shizuto Mizuire** and **Toshio Kutsunai** of Hilo attended the American College of Surgeons meeting in Chicago.

**Dr. Irvin A. Rothrock** is taking over **Dr. Sam Brown's** practice in Hilo while Dr. Brown is vacationing on the mainland.

**Dr. Victor V. Donahey,** associate physician at Olaa Sugar Company, left for Los Angeles November 1, where he will resume practice in San Fernando Valley, Los Angeles.

**Dr. and Mrs. Walter S. L. Loo** welcomed a son who weighed 7 lbs. 10 oz. on September 8, 1953. The Loos now have a family of three boys and two girls.

**Dr. George D. Oakley** was appointed head physician for the Laupahoehoe Sugar Company effective November 1, 1953.

## Kauai

**Dr. and Mrs. Sam Wallis** have recently returned from their well deserved vacation on the mainland. Their mainland itinerary included a visit to Canada. During Dr. Wallis' absence, **Dr. Maxwell Boyd** substituted.

**Lieutenant Keith Kuhlman** was a recent visitor out here. He has spent a year of service in Korea and is now stationed at the Tripler Army Hospital. He is planning to return to Kauai and resume his practice post-discharge 8 months hence.

# NEWS

## Annual Meeting of the AHA, 1954

The Annual Meeting of the American Heart Association in 1954 will be held at the Conrad Hilton Hotel in Chicago. The Assembly Panels and the General Assembly will be held on Thursday and Friday, April 1 and 2, and will be followed by a specific scientific program on clinical cardiology on Saturday and Sunday, April 3 and 4, conducted under the auspices of the newly formed Section on Clinical Cardiology of the Scientific Council. These sessions will immediately precede the annual meeting of the American College of Physicians.

## Award for Outstanding Research in the Field of Infertility

The American Society for the Study of Sterility announces the opening of the 1954 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of $1,000, and the essay will appear on the program of the 1954 meeting of the Society. Essays submitted in this competition must be received not later than March 1, 1954. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, c/o Dr. Herbert H. Thomas, Secretary, 920 South 19th Street, Birmingham, Alabama.

The author should append on a separate sheet of paper a short biographical sketch of himself and include a photograph to be used in the necessary publicity should he be the winner of the award.

## Fellowships in Tuberculosis Research

The American Trudeau Society, Medical Section of the National Tuberculosis Association, provides a limited number of fellowships to promote the training and development of investigators in the field of tuberculosis and related pulmonary diseases. Stipends are determined by individual circumstances and may vary from $3,000 to $3,600 per annum for full-time service. Appointments may begin on any date determined by the Board.

Further particulars concerning these fellowships may be obtained from The Director of Medical Research, American Trudeau Society, c/o Henry Phipps Institute, Seventh and Lombard Streets, Philadelphia 47, Penn.

# UMI MAKAHIKI I HALA*

## Honolulu County Medical Society

*Membership.*

New members accepted were:

**Capt. George S. White (service)**
**Edmund L. Lee**
**Alvin V. Majoska**
**B. M. Eveleth**
**Robert G. Johnston**
**Robert F. Bailey**
**M. Yamashiro**
**S. Inamine**
**John M. Felix**
**E. F. Slaten**
**Wm. M. Walsh**

**Lt. Volt H. Tom,** M.C., U.S.A., was voted to honorary membership posthumously. Lt. Tom was a native of the islands who lost his life at Guadalcanal.

*Hospitals.*

Staff appointments. The Board of Governors was asked to draw up a statement of policy regarding the appointment to hospital staffs of aliens or American citizens of German or Japanese ancestry. It seems that there is often considerable controversy on this point and the Board drew up the following resolution to present to the membership:

WHEREAS it has come to the attention of the Board of Governors in recent months that the question has repeatedly been raised as to the propriety of appointing to local hospital staffs physicians of alien birth, or physicians who are American citizens but are descendants from countries with which the United States is at war,

BE IT RESOLVED that the Honolulu County Medical Society go on record as recommending to the hospitals that the eligibility for appointment to such hospital staffs be on the basis of licensure to practice medicine in the Territory of Hawaii and that the physician be known to be in good standing, professionally and ethically, and that it is not considered within the province of the medical society or the hospitals to adjudge a man's standing, politically or nationally; that task presumably being in the hands of appropriate agencies of the government.

*Finances.*

A special committee appointed by the President to study the budget for 1943-1944 (which, including the $3,000 appropriation made to the library, was expected to show a sizeable deficit) made the following recommendations:

(1) To ask the Territorial Association to appropriate $500.00 to the library as last year, without assessment to the counties;
(2) To levy an assessment of $15.00 per member;
(3) In order not to make necessary an increase in dues, that the society build up a general fund, with the following as possible sources:
  (a) Charge for services of staff doctors on City and County and Department of Welfare patients, on the basis of 20 per cent of the hospitalization bill.
  (b) Pay into the society, instead of to individuals, the moneys accumulated in the Physicians' Reserve Fund of the HMSA.

At the November Board of Governors' meeting a proposal was presented to build up a library endowment fund, asking for voluntary contributions from doctors, and asking commercial houses to match the funds so raised. It was voted that a letter be prepared for approval of the Board.

*Journals.*

The largest single contribution [to the library] was the acquisition of a large portion of the medical library of the Kalihi Receiving Station. This collection brought us bound volumes of many journals extending back many years and added files of other journals which our library was not carrying.

*Changes.*

There have been several new line-ups in recent months: **Dr. John M. Felix** has joined **Dr. L. A. R. Gaspar, Jr.; Dr. Robert Bailey** has his offices with **Dr. Culpepper; Dr. William Walsh** has gone in with **Doctors Batten** and **Bell; Dr. Alfred S. Hartwell,** formerly medical director of The Queen's Hospital, has been added to the medical department of The Clinic; **Dr. Robert Johnston** has returned to Honolulu and is practicing general surgery with The Medical Group; **Dr. Alvin Majoska,** formerly resident in pathology at Queen's, has taken over the office of the late **Dr. O. Lee Schattenburg; Dr. H. S. Dickson** has taken over **Dr. Osorio's** practice, **Dr. Osorio** having left for the mainland.

* Ten years ago. From Volume 3, Number 2, November-December, 1943.



Various factors during pregnancy (intestinal displacement, atony, inactivity) make it virtually impossible for most women to go through the gestation period without constipation.

# CONSTIPATION IN PREGNANCY:

## *Satisfactorily controlled with Metamucil®*

Metamucil, with its physiologic principles of "smoothage" and "normohydration," is well tolerated for pregnancy constipation. This bland vegetable colloid may be used throughout the entire nine-month period without fear of forming a "habit" and without irritation to the mucosa.

Greenhill[1] suggests that Metamucil be given every other night. He also recommends that Metamucil be given in conjunction with a proper diet, during the lying-in period of the puerperium.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Greenhill, J. P.: Principles and Practice of Obstetrics, ed. 10, Philadelphia, W. B. Saunders Company, 1951, pp. 103-104; 311; 332.



# Terramycin

BRAND OF OXYTETRACYCLINE

## an agent of choice in urinary tract infections

- *promptly effective against a broad-spectrum of urinary pathogens*
- *high concentration in active form in urinary tract*
- *well tolerated, even upon prolonged administration*

**Terramycin is acclaimed by urologists everywhere for unsurpassed action in**

***chronic urinary tract infections***

***acute urinary tract infections***

***urinary tract surgery***

"The resistant cases showed remarkable response."[1]
". . . has cured where all other antibiotics have failed."[2]

"Patients with pyelitis were well and doing their usual duties within 24 hours . . ."[3]

"Morbidity from apparent genito-urinary causes was noted in only one patient of 44 patients who received prophylactic Terramycin."[3]

"Terramycin is generally well tolerated, the percentage of relapses being low and the percentage of bacteriological as well as clinical cures high."[2]


1. Ferguson, C., and Miller, C. D.: J. Urol. *67*:762 (May) 1952.
2. Trafton, H. M., and Lind, H. E.: Ibid. *69*:315 (Feb.) 1953.
3. Blahey, P. R.: Canad. M. A. J. *66*:151 (Feb.) 1952.


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# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAM, *Executive Secretary,* Honolulu

BULLETIN COMMITTEE

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## PRESIDENT'S MESSAGE

### ANNUAL MEETING, 1953

Nursing as an art and science has undergone radical changes during recent years. With the introduction of new drugs, variously called "wonder drugs," "miracle drugs," etc., our concepts of nursing care have wondrously and miraculously been transformed from Dakin Solution irrigations and flaxseed poultices to intramuscular injections and psychosomatic considerations. Seriously, however, many of you recall the drama of the pneumonia crisis; the revulsion you experienced, the first time you saw a victim of smallpox; the fear you knew when a diagnosis of ruptured appendix was made. New surgical procedures continue to astound us. The nursing care of the surgical patient has been revolutionized even though we have not reached the stage where the major surgery patient arises from the operating table and walks to his bed. There have been changes, yes, indeed!

Nursing as an occupation has a "new look" too. Florence Nightingale no doubt would react violently to the required curriculum in a school of nursing. Clara Barton would be shocked at a nurse in slacks rendering nursing care to a soldier 2,000 feet above the ground, in an airplane, of all things! Terms we use so freely: socio-economic structures, nursing function surveys, the nursing team, counseling and placement services—would have a foreign sound to the girls of 1910, 1920, and even 1930!

In spite of all the evolution, revolution, or whatever you choose to call it in nursing, it is interesting to point out that basic principles have not changed. The objectives have not changed. Today as yesterday or a century ago, nurses are concerned with the welfare of the sick, the helpless child, the aged. The desire to serve still motivates the young woman who says "I've always wanted to be a nurse." We should be proud that this is true. No longer do counselors advise students who are "not too bright, but sweet, awfully healthy and strong" to choose the field of nursing. Top students in a given class are screened and tested carefully before they are accepted into the rigorous mental and physical period we call "training." Nurses are able to participate actively in groups of business and professional women, in civic betterment groups, and in cultural circles.

While we are busily engaged in obtaining good students, excellent educational and clinical facilities for the prospective nurse—while we are concentrating on adequate pay, satisfactory working conditions, security measures and acceptable periods of work time—while we are considering higher education and specialized training for the professional nurse—let us not forget that these are but means to help us reach our unchanging objective — to render the best possible nursing care to the patient who has been entrusted to us.

ELIZABETH MCCALL, R.N.
*President*

## HOW MANY HAVE YOU BROUGHT IN?

Membership in the Nurses' Association, Territory of Hawaii, for the current year has surpassed all previous records. Total membership reported at the annual meeting was 806.

There are approximately 1500 nurses registered in the Territory; our association membership represents a little over 50 per cent of this number.

What can we do to increase this percentage?

Membership promotion is the task of finding, informing and convincing non-members that your association is vital to them and needs their participation. If we double our membership, it will mean a tremendous increase in the resources and effectiveness of the American Nurses' Association and of our Territorial Association, as well as of every occupational section.

The largest group of potential active members is in hospitals and schools of nursing. On a national level, the American Nurses' Association "Facts" lists 216,047 nurses, exclusive of those in private duty, engaged in professional nursing in hospitals and schools of nursing. Yet only about 86,000 of them are ANA members. Private duty nurses have heretofore been the largest single occupational group in the American Nurses' Association but not even all private duty nurses are ANA members.

The second largest group of potential members is composed of nurses who are not active in their profession — young marrieds, mothers, retired nurses. Many have time and talents to invest and are in a position to form strong links with other community groups.

A "Membership Committee" can spearhead a membership campaign, but it cannot do the job alone. Only through the combined efforts of every member of the association, whether she be a staff nurse or the director of a nursing service, can we make the personal contacts and interpret the goals of our professional association.

We each have this responsibility to our association if it is to grow and meet the demands of our society.

## ACTIONS OF YOUR BOARD OF DIRECTORS

August 27, 1953

*Heard* letter from the Board of Trustees, Mabel Smyth Building, and accepted proposal of increased rents. (Since this meeting we have been notified that along with the increase in rent as of January 1954, the fifteen cent service charge will be eliminated.)

*Discussed* letter from Hawaii Medical Association. Medical Journals (Inter-Island Bulletin) returned because of incorrect address cost 15 to 27 cents each for the return. Remailing them is additional. The Medical Association feel that they cannot carry this cost. The Board is referring the matter to the district associations.

*Approved* rules of the Public Health Nurses' Section.

*Approved* all expenses of Board members to Honolulu four times a year; but for the annual meeting, travel only.

*Discussed* use of legal counsel and approved use of same counsel as in the past two years as necessary for ordinary matters; the service of an attorney experienced in employer-employee relations is to be secured for matters pertaining to the economic security program.

## BRIEFS ON THE ANNUAL MEETING

A stirring welcome was given by Miss Elizabeth Morishige, President of Maui County Nurses' Association, in true public health nurse style with visual aids to stimulate our interest and curiosity.

Total registration—182 (usually around 200 in Honolulu).

Approximately 90 nurses took field trips on the third day of the meeting—to Haleakala, Hana, and Central Maui. A number greeted the sun over the crater at 6 a.m., peering from under blankets, or roly poly from extra sweaters and even towels wrapped around under skirts!

Thirty-four Maui nurses volunteered to take care of transportation during the meetings. They also managed to attend!

The "Coca-Cola man," who hears many conventions, takes his hat off to the nurses, who know their business and how to get it done!

Hospitality doesn't "just happen"—and the hospitality shown to all of us attending the Maui meeting is making Oahu nurses think!

## ACTIONS OF HOUSE OF DELEGATES

ANNUAL MEETING, NATH

August 28 and 29, 1953

*Heard* reports of committees, sections, districts, and special representatives.

*Accepted* budget of $10,404.83 for 1954.

*Requested* that the budget be pro-rated to the districts using the same formula as in the past.

*Accepted* revisions of by-laws as sent to the membership preceding the annual meeting.*

*Accepted* the following resolutions:

## RESOLUTIONS ACCEPTED BY THE HOUSE OF DELEGATES OF NATH AT THE 22ND ANNUAL CONVENTION

# 1

WHEREAS, The by-laws have been revised to make section chairmen members of the Board of Directors, and

WHEREAS, Statements of policies as they affect section budgets and expenditures are needed, be it

RESOLVED, That the Board of Directors be authorized and requested to formulate such policies.

# 2

WHEREAS, The membership of the Nurses' Association, Territory of Hawaii, Inc., authorized the development of an economic security program at its annual meeting on September 29, 1950, and

WHEREAS, When the Board of Directors, in attempting to carry out the desires of the membership in regard to said economic security program, gave each individual member the opportunity to vote for or against the program, less than one-half of the membership voted, and

* If you will insert those proposed revisions in your January-February 1953 HAWAII MEDICAL JOURNAL, pp. 223-231, and make the changes indicated in resolution number 4, you will have your by-laws up-to-date.

WHEREAS, The American Nurses' Association recommends the development of standards of employment as absolutely essential through its sections and the professional nurse feels the need for direct leadership in the forwarding of this program, be it

RESOLVED, That the Board of Directors of the Nurses' Association, Territory of Hawaii, Inc., be authorized to poll the membership again for authority to act as its sole bargaining agent when needed.

# 3

WHEREAS, The Economic Security Committee has recommended that a resolution be presented to the House of Delegates' meeting requesting a poll of the membership to give the Board of Directors of the Nurses' Association, Territory of Hawaii, Inc., authority to act as its sole bargaining agent (in matters of economic security), and

WHEREAS, The Public Health Nurses' Section feels that time is needed to interpret the program to the general membership, and

WHEREAS, The members of the Public Health Nurses' Section plan to orient their fellow members, therefore be it further

RESOLVED, That this poll shall not be held until after November 1953.

# 4

WHEREAS, The present by-laws require a meeting of the Board of Directors and the Advisory Council immediately following the close of the annual convention, and

WHEREAS, This allows insufficient time for collection of reports and recommendations for consideration, be it

RESOLVED, That the by-laws Article VII, Section 2, be revised to allow the post convention meeting of the Board of Directors to be held at a later date to be decided upon by the Board of Directors when minutes and reports of the meetings are compiled and available, and also be it

RESOLVED, That Article IX, Section 2, be revised to eliminate the post Advisory Council meeting.

# 5

WHEREAS, Recommendations are formulated by standing and special committees of the Nurses' Association, Territory of Hawaii, Inc., to advance the work of the association, and

WHEREAS, These committees are well qualified through their committee work to make recommendations, therefore be it

RESOLVED, That any committee desiring action on recommendations in the House of Delegates prepare such recommendations as resolutions for study and presentation by the Resolutions Committee.

# 6

WHEREAS, The Legislative Committee is of utmost importance to our progress in community activities, and

WHEREAS, The opinion of the Nurses' Association is receiving more consideration in the matter of health legislation, and

WHEREAS, This committee has requested the formulating of a policy whereby guidance in health legislation may be determined,

We, therefore, RECOMMEND that the Board of Directors of the Nurses' Association, Territory of Hawaii, Inc., appoint a committee to study and formulate a plan whereby the desires of the county associations in health legislation be determined and transmitted to the Legislative Committee.

# 7

WHEREAS, The members of the National Nurses' Association recognize the value of the practical nurse in a correlated nursing team, and

WHEREAS, We recognize the importance of organization for growth and development, be it

RESOLVED, That the Nurses' Association, Territory of Hawaii, Inc., acknowledge and congratulate the newly formed Practical Nurses' Association of the Territory of Hawaii and co-operate fully in the achievement of common endeavors, and that a copy of this resolution be sent to the president, Practical Nurses' Association, Territory of Hawaii.

# 8

WHEREAS, The Maui District Association has shown outstanding ingenuity, organization, and hospitality in sponsoring the first annual meeting on a neighbor island, and

WHEREAS, All present have had a thoroughly enjoyable time, we hereby RECOMMEND that a rising vote of thanks be given the Maui District Association, and that this resolution be made a part of the Resolutions Committee report.

# 9

WHEREAS, Rev. Mother M. Jolenta has made an outstanding contribution to nursing since her arrival in Hawaii in 1933, and

WHEREAS, She has been very active in nursing associations and civic organizations that have made great progress in improving the health and social welfare of the people of Hawaii, and

WHEREAS, She has displayed superior ability as a hospital administrator and a leader in community activities, and

WHEREAS, Her great kindness and understanding have been an inspiration to all who knew her, and

WHEREAS, She has been the first Sister from Hawaii and the first professional nurse so honored as to be elected Superior General of her community, therefore be it

RESOLVED, That the Nurses' Association, Territory of Hawaii, Inc., assembled for its 22nd Annual Convention congratulate Sister Jolenta on the great honor bestowed upon her; also be it further

RESOLVED, That the Association express regret that such an outstanding personality will no longer participate in our diverse program; be it further

RESOLVED, That a copy of this resolution be published in our Bulletin and the local papers and a copy sent to the General Council of the Sisters of the Third Order of St. Francis in Syracuse, New York, assuring the Order of the high esteem in which Sister Jolenta is held by the Nurses' Association, Territory of Hawaii, Inc.

# 10

Courtesy resolution thanking all those who contributed to the success of the 22nd Annual Meeting.

## NEWS FROM DISTRICT ASSOCIATIONS

### County of Kauai

New arrivals at Wilcox Memorial Hospital include Miss Miyoko Iwai, Miss Barbara Fujimoto, Miss Euphemia Padilla, and Miss Agnes Nakakura.

Miss Teruko Fujimoto left Wilcox on September 19 to attend the University of Hawaii to obtain a degree in Public Health Nursing.

Miss Martha Hiramoto's engagement to George S. Ohama was announced on September 12. Their wedding is planned for November 7.

Vacationing on Kauai is Miss Edythe Kamida. After completing a postgraduate course in O.R. at Johns Hopkins, she worked at the University Hospital at Ann Arbor, Michigan, before coming home.

On September 5, at the Wilcox Memorial Hospital Nurses' Home, Mrs. Vina C. Candage was married to Alexander G. Hutton, with the Reverend Ford Coffman officiating.

Twenty-two graduates of The Queen's Hospital School of Nursing held their annual reunion on September 10 at the Hanamaulu Cafe. Present were Mrs. Miyoko Masunaga, Mrs. Sueko Muraoka, Mrs. Mikiyo Tao, Miss Lillian Chong, Mrs. Tsugie Kadota, Mrs. Ruth Masunaga, Mrs. Marian Kawate, Mrs. Kay Onzuka, Mrs. Nobuko Hayashi, Mrs. Betty Sora, Miss Edythe Kamida, Mrs. Tomi Kutaka, Miss Florence Muraoka, Miss Martha Hiramoto, Miss Elsie Watanabe, Miss Fukiko Izawa, Miss Teruko Fujimoto, Mrs. Alice Togikawa, Miss Myra Kurihara, Miss Margaret Imamura, Miss Hilda Nemoto, and Miss Miyoko Iwai.

### County of Hawaii

*Convention Notes*

The seventeen Hawaii Island nurses who attended the annual meeting on Maui were a true cross section of nurses everywhere; they were young staff nurses; they were older retired nurses whose interest and loyalty to their profession goes on although working days are over; they were members of many occupational groups—general duty, industry, public health, private duty, and administration. And like everyone else who attended the convention, Hawaii's nurses were full of praise for the Maui Association. Indeed, Maui nurses typified the theme of the convention for they truly worked together to make it the success it was.

It is difficult to be brief in any discussion of this year's meeting. Each detail seems important enough to mention —there are no "highlights," for it was all good and all worth while.

At the end of the convention perhaps the outstanding feeling was one of pride, pride of belonging to an organization whose members can get together and work out their problems calmly, quietly, and practically. Nurses may be idealists, but we are realists too; both were in evidence at the convention.

We do not always agree, but that is a good thing as long as we are willing to work together in the best interests of the whole association.

I think that every one of the Hawaii nurses who attended the meeting will work harder next year. We were interested by all we saw and heard, but best of all was the shining example the Maui Association gave us of "working together."

*Personals*

Mrs. Elizabeth Stillman has returned to work at Hilo Memorial Hospital as Assistant Director of Nurses.

Mr. and Mrs. Kiyoyuki Nakatsu announce the birth of a son on September 21, 1953. Mrs. Nakatsu, the former Soon Yur Kim, is on leave of absence from the Department of Health.

Miss Helen Gorsuch and Miss Mary Jean MacDonald returned to Hawaii on August 31 after two months vacation in the State of Washington.

Department of Health nurses have been honored recently by guests from afar. Miss Mei Li Lee of Formosa spent a week in Hilo as part of her field work in public health nursing. Mrs. Sabra Sadler, Nursing Consultant in Rheumatic Fever for the State of Virginia, was an unofficial but interested and interesting visitor.

Mrs. Nettie Morimoto, industrial nurse for Hakalau, Pepeekeo and Onomea Sugar Companies, is attending the University of Hawaii, taking courses in Public Health Nursing.

## WELCOME TO NEW OFFICERS

NATH:

Lt. Col. Eileen Brady, Tripler Hospital—First Vice-President
Isabel Medeiros, Leahi Hospital—Secretary
Myrna Campbell, Dept. of Health, Kauai — Board member, Kauai
Elaine Johnson, Maunalani Hospital & Convalescent Home—Board member.

SECTIONS:

*General Duty Nurses:*
Chairman: Leila Miyamoto, Queen's Hospital
Vice Chairman: Marilyn L. Estill, Wailuku, Maui
Second Vice Chairman: Emily Kaaua, Hilo Memorial Hospital, Hilo
Secretary: Sumiko Takahashi, Queen's Hospital

*Industrial Nurses:*
Chairman: H. Eileen MacHenry, Paia, Maui
Vice Chairman: Edna Baldwin, Pepeekeo Dispensary, Pepeekeo, Hawaii
Secretary: Lillian Gill, Paia, Maui

*Public Health Nurses:*
Vice Chairman: Josephine Cortezon, Koloa, Kauai
Secretary: Emilia Centeio, Kapahulu Health Center

*Institutional Nursing Service Administrators:*
Chairman: Sister Mary Albert, St. Francis Hospital
Vice Chairman: Lt. Col. Eileen Brady, Tripler Hospital
Secretary: Irene Snyder, Children's Hospital

## ARE YOU A MEMBER OF THE HAWAII LEAGUE FOR NURSING?

The Hawaii League for Nursing is nearing the close of its first year of organization. The members have showed much active interest in the reorganization and each has helped in recruiting new members.

The membership has increased 20 per cent and we are expecting to make it higher for the coming year.

1953 dues were paid to National as well as to your local League. 1954 dues are to be paid only once, to the Hawaii League for Nursing, which will cover both local and national dues.

If you are a Registered Nurse—in a school, hospital, industry, or office, general or private duty, public health, administration, education, in the Armed Forces, or, if you are not a nurse but a board or committee member, faculty member, or community leader, you will want to join the League for Nursing. The Hawaii League needs you and you need the League to build a strong and active group to work for better nursing in all of our communities. JOIN NOW!

SARA JANE TRAINOVICH, R.N.
(Queen's Hospital)
*Chairman, Membership Committee*

## ALOHAS FROM I.C.N.

(Brought by Gloria Foster and Mabel Gordon)

*Alfield M. Christophersen*—formerly at Kapiolani and Kona Hospitals. 1938-1945 was a major in the Army Nurse Corps. Present address: Rte. 1, 238-B, Sonoma, California.

*A. L. Rutherford*—Public Health Nurse, Kauai, 1944. Now with Institute of International Affairs (WHO), Costa Rica.

*Charlotte Kerr*—was in Panama with WHO. Left Panama for U.S.A. August 1. Hello to everyone!

*Katherine Densford*—former president of ANA. Sent regards to all Minnesota girls.

*Ella Best*—Executive Secretary of ANA. Aloha everybody!!!

*Anne Fisher*—with I.I.A.A. Address: c/o American Embassy, San Salvador, El Salvador.

*Mary Dunn*—from U.S.P.H.S. Here in 1948. Gave institute on Social and Health Aspects in the Curriculum. Now retired.

## TAX DEDUCTIONS FOR CONVENTION EXPENSES

Ruling received by ANA from the Bureau of Internal Revenue:

"The ruling as to private duty nurses, and other nurses who have an independent contractor status, holds that convention expenses, including not only travel and lodging, but also fees and other expenses, are deductible in arriving at 'adjusted gross income,' which means that the standard deduction is available in addition. With respect to nurses who have the status of an 'employee,' the portion of convention expenses which represents travel, hotel, etc., may generally be deducted in arriving at adjusted gross income, while the remaining portion may be deducted if the standard deduction is not taken. However, a nurse who is an employee must be prepared to show that the convention expense was an 'ordinary and necessary business expense,' which means, in nontechnical language, that it must be reasonably related to her job. On this particular point, factual situations may give rise to some controversy with local offices of the Internal Revenue Service."

## "EXTRA-CURRICULAR" ACTIVITIES OF THE PRACTICAL NURSING SCHOOL

As we begin our seventh year of operation of the Practical Nursing School, you may be interested in what we have done to help non-graduates of the school to obtain more information about nursing procedures and to qualify for the licensing examination.

During 1948-1950 three 32 hour classes were given for employed practical nurses licensed by waiver. They were well attended and at the end of the period students received a certificate. An inservice course was also given at Maluhia Home during the time for all practical nurse personnel employed there.

In 1950 a two year evening class began in Honolulu with 31 students enrolled. At the end of the prescribed period, 16 were graduated. Then in 1951 Hilo began their two year evening class with 60 students, 31 of whom finished. Also during 1951 an intensive ten day course was conducted at Kula Sanatorium and Mahelona Hospital for their employed practical nurses.

Last year (1952) a second two year evening class began in Honolulu with 32 students enrolled, 24 of whom are now attending and in good standing. This course will be completed early in 1954.

In the spring of this year a 12 hour "postgraduate" course was given to 30 students. All licensed practical nurses were eligible. Much the same course will be repeated this fall.

A second two year evening course is now in the process of being organized in Hilo. Plans are well under way and screening of students is being done as the BULLETIN goes to press.

Practical nurses and hospitals on Maui are very interested and eager to begin a course there. Maui's known qualified nurses have been unable to accept the position of instructor so the Practical Nursing School would be very grateful to hear of any interested and qualified nurses.

The Vocational Division of the Department of Public Instruction (through the Practical Nursing School) is eager to co-operate in every way possible to bring these courses to any area. Qualified instructors are paid through the D.P.I.

In this program of bringing nursing care, done by practical nurses, up to a minimum standard, many instructors have participated as well as members of the Practical Nursing School staff.

## NEW PAMPHLET URGES EVERY COMMUNITY TO PROVIDE PUBLIC HEALTH NURSING SERVICE FOR THE SICK AT HOME

Every community should make public health nursing service available to all people sick at home who need it. To be adequate, this service should not be limited only to short periods for demonstration. The frequency of the public health nurse's visits to a family and the amount of service she gives should be determined by the needs of the patient and his family, regardless of whether the illness is acute or long-term.

These are some of the conclusions reported in *Public Health Nursing Care of the Sick at Home* which has just been published by the Department of Public Health Nursing, National League for Nursing. The report summarizes the discussion and points of agreement reached by 85 participants who represented both governmental and voluntary agencies during the recent Arden House Conference.

In deciding whether a health department or voluntary agency should administer the program for nursing care of the sick at home, according to the report, first consideration needs to be given to what is best for the people and through which organization the best service can be provided economically, efficiently, and effectively. Regardless of the sponsorship, people should be encouraged to pay for service on a cost basis in accordance with their ability to do so.

"Many people fear that including public health nursing care of the sick at home among the services of an official health department will decrease the essential preventive services," the report states. "But experience has shown that it is possible to maintain a balanced public health program if the nursing and medical administrators will plan and work together cooperatively. Of course, realistic priorities must be set up to safeguard all essential activities. These can't be established nationally but must be arrived at locally and must be related to the community's age composition, occupational hazards, sickness and death rates, etc."

The report also emphasizes the importance of the people's participation. Not only must they determine the type of service they are to have; they should participate "in the development, promotion and evaluation of the policies and services. This citizen participation should be representative of lay and professional groups, as joint citizen and professional leadership is essential for a sound program."

In addition to presenting the conclusions and agreements of the Conference participants, the report includes papers presented by panel speakers, each an expert in his or her field: Bradley Buell, George St. J. Perrott, Dr. Franz Goldmann, Ruth Weaver Hubbard, and Dr. Roscoe P. Kandle.

In his paper Mr. Perrott points out that death rates are inadequate to give a picture of the nation's health because they do not indicate the frequency and duration of illness. The relative importance of various causes of disease is better measured by the disabling cases and the number of disabling days per person per case per year.

"From the standpoint of the patient and his family," Mr. Perrott continues, "the duration of each individual case of illness is an important measure of its severity and economic consequences. Ranked in descending order of the number of days of disability per case we find, as we would expect, many of the long-term chronic diseases," with epilepsy, psychosis, tuberculosis, and diabetes among the first four.

Stating that recognition of the importance of home nursing as well as home care in general is becoming increasingly widespread, Dr. Goldmann calls for immediate action. He urges that home care be developed first of all because patients need it and not solely to free precious hospital beds for use by people who need them nor merely to provide professional education.

"If we place the major emphasis on the desire to free hospital beds," according to Dr. Goldmann, "then we may easily get into a situation where we use home care as a cheap substitute for good hospital care and this would be a disaster."

In presenting "closing remarks" on the conference, Dr. Kandle summarizes: "The concept that medical care consists of a totality of care of the sick—prevention, rehabilitation, and health promotion—is pretty generally accepted by the professions and the public. There are now rich resources in this country on which to build, exemplified by the 75 years of visiting nurse service experience and also by our experience with medical care and public health services. It is now time to stimulate health officers, for example, to see public health nursing care of the sick as an integral part of all public health nursing services. It is time to develop sound comprehensive home care service as a logical part of community-provided medical care. The question is, can we do it?"

Copies of the 57-page report may be ordered from the National League for Nursing, 2 Park Avenue, New York 16, New York. Price: $1.00 each.

## MEDICAL LIBRARY

The Medical Library in the Mabel Smyth Building now has copies of *The American Journal of Nursing* since 1916. There are some missing issues from 1923 to 1928. If anyone has these issues, we would greatly appreciate their donation to the library. Books from this library are available to members of the Nurses' Association outside of Honolulu upon request. The cost would be only the cost of mailing the book back to the library.

## BOOK REVIEWS

*Society and the Nursing Profession.* By James R. Reinhardt and Paul Meadows, 256 pp., Price $3.50, W. B. Saunders Company, 1953.

The authors are sociologists and have written a text which includes a substantial background of sociology and yet it is coordinated with nursing—"the history of nursing in the United States as an integral part of the history of a whole social movement is especially related to changing concepts of the social importance of good health."

Understanding of the patient as a person is clearly portrayed in the chapter titled "The Sociology of the Patient." The following captions taken from this chapter will reveal that the authors have an understanding of the emotional factors involved in illness: The Patient as Sufferer, Illness as an Adjustment Situation, The Anxiety Component in Illness, Illness as a Rupture of Routine, and Emotional Factors in the Treatment Process.

The following titles of other chapters in this text will reveal very important considerations which need to be clearly understood by all nurses: "The Family and Society," "The Human Community," "Problems of Child Welfare," "Juvenile Delinquency," "Sociological Aspects of Physical Well-Being," "How Shall Health Resources be Used?" and "The Nurse and Social Worker."

In the chapter, "Sociology of Crime," a nurse becomes familiar with her role in professional relations with families and community agencies; she will be better prepared to take advantage of the opportunities whereby she can assist unfortunate people by advising them to contact the various community agencies available for counsel and assistance when needed.

This book is exceedingly well written in a clear yet concise manner; it should be included in every school of nursing library.

CYNTHIA L. WOLFE, R.N.

* * *

*Nursing in Diseases of the Eye, Ear, Nose and Throat.* From the Manhattan Eye, Ear and Throat Hospital, Ninth Edition, 317 pp., Price $4.00, W. B. Saunders Company, 1953.

The contents have thoroughly kept pace with the rapid changes and advances in the treatment and care of the eye, ear, nose and throat patients. Notably, the chapters on Ocular Therapeutics, Nursing Procedures in Eye Conditions, External Diseases of the Eye, and Internal Diseases of the Eye are complete and yet without too much verbiage and are ably re-written to meet the present needs.

The chapters on the ear, nose and throat have also been re-written to fit present trends. Although the material is not as thorough as that covering the eye, yet it more than supplies the need for student nurses. The book as a whole is concise and factual. The statements of facts are clear and to the point. However, the language in certain parts is very technical and little attention is given to explaining the relationship of eye, ear, nose and throat conditions to other phases of medicine and surgery. The editors assume that the student has adequate information in these phases.

It also gives an impression that many of the passages are written mainly for nurses who are doing work in these special fields. The bibliography is compact and all references can be found in the volumes of the *American Journal of Nursing,* which makes it valuable for stu-

dents desiring extra reading. The glossary is informative and is of great value for quick references.

The photographic illustrations are clear cut but the diagrammatic sketches are crowded and legends are tedious to decipher and may not hold the students' attention for long. Use of this book should, therefore, be guided by the knowledge that supplementary reading material and instruction are necessary to help the student understand the medical, surgical, and nursing aspects of the intricacies of eye, ear, nose, and throat diseases.

SISTER FRANCES CABRINI.

## FOR YOUR READING PLEASURE

A former public health nurse on Lanai, Miss Lucille Sandberg, has written a book of poems, "Six Islands," soon to be available in Island book stores. The first chapter is devoted to Lanai. Many of her poems originally appeared in "The Lanaian" in 1949-50. She is now a school nurse in Willows, California.

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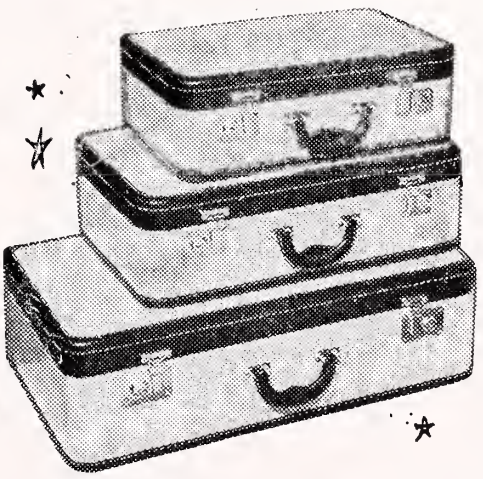
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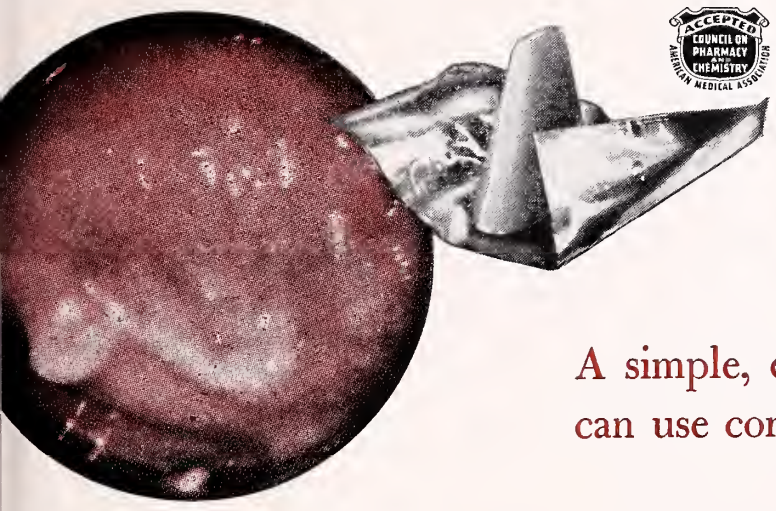
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* **REFERENCES:** Eastman, N. J., and Seibels, R. E.: *Efficacy of the Suppository and of Jelly Alone as Contraceptive Agents,* J. A. M. A. 139:16, 1949. • Eastman, N. J.: *Further Observations on the Suppository as a Contraceptive,* South. M. J. 42:346, 1949. • Eastman, N. J., and Scott, A. B.: *Phenylmercuric Acetate as a Contraceptive,* Human Fertility 9:33 (June) 1944.

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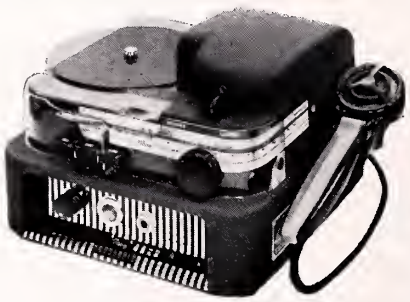
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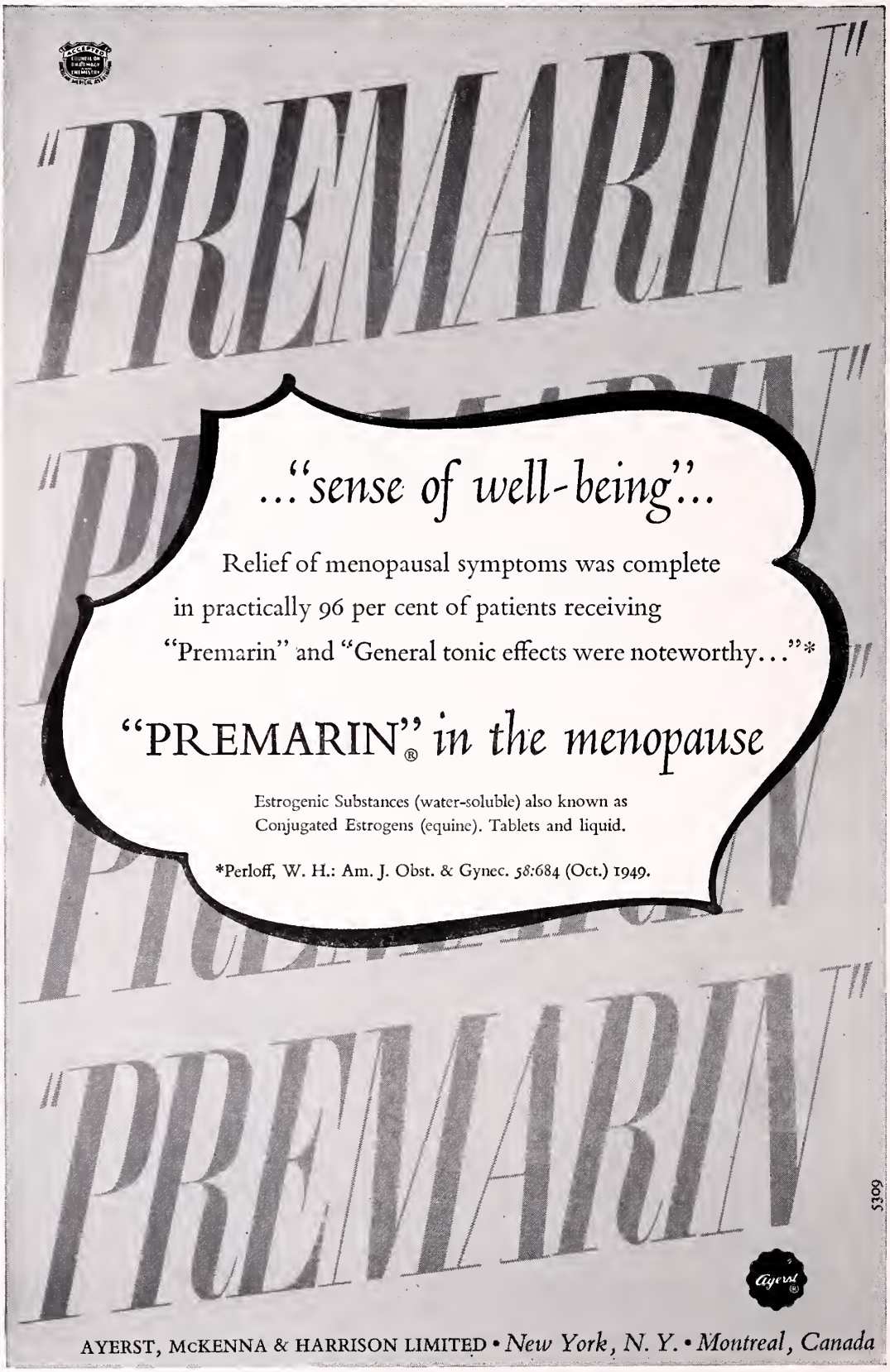
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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.
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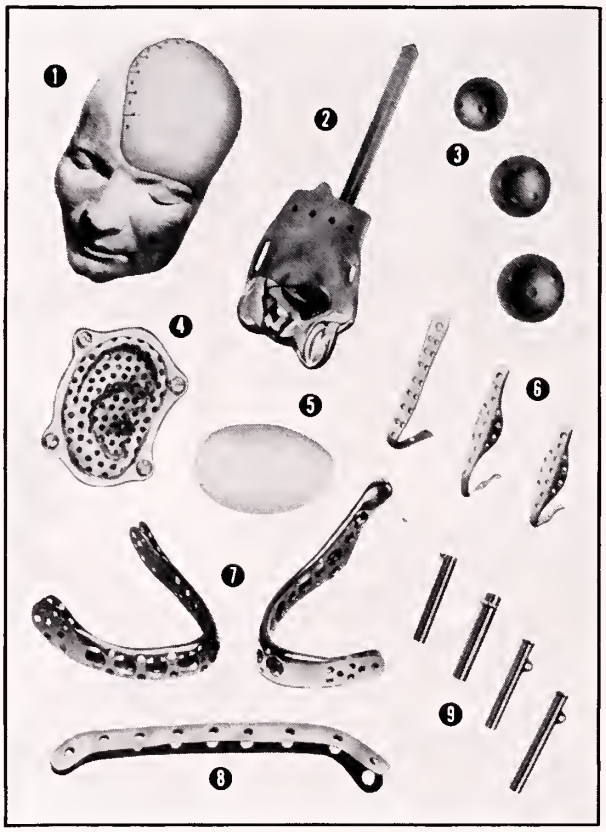
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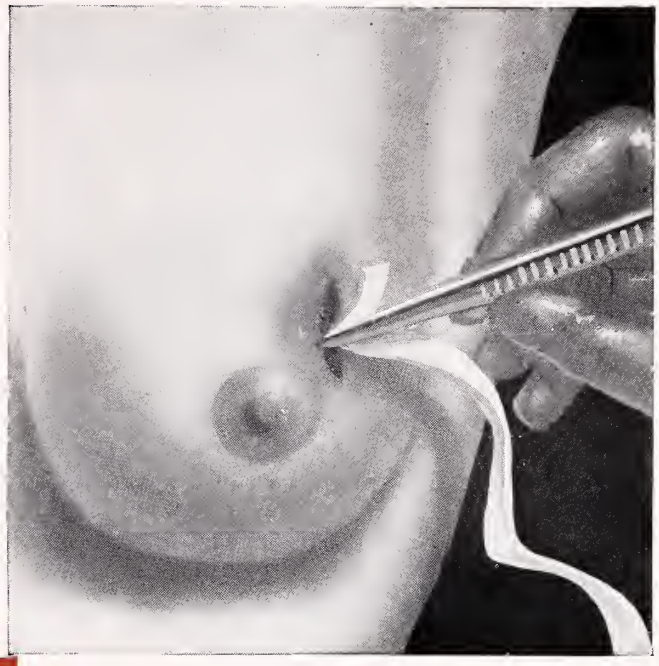
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1. Marchisello, P. J., Prigot, Aaron, and Wright, L. T.: Am. Jour. Surg., Dec., 1952






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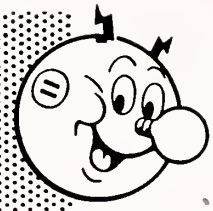


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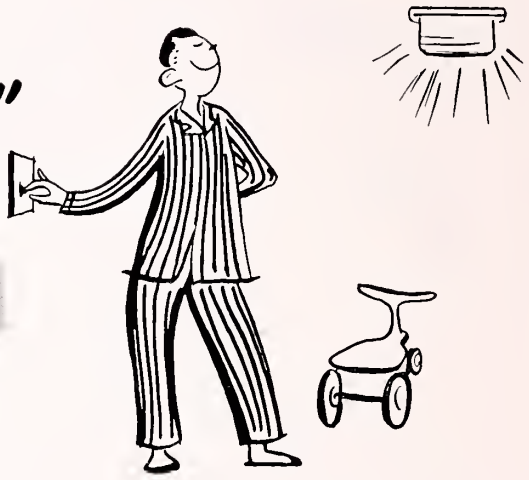


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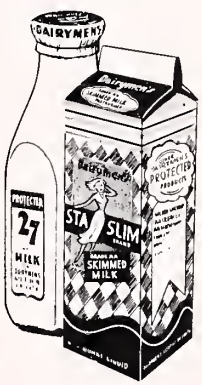


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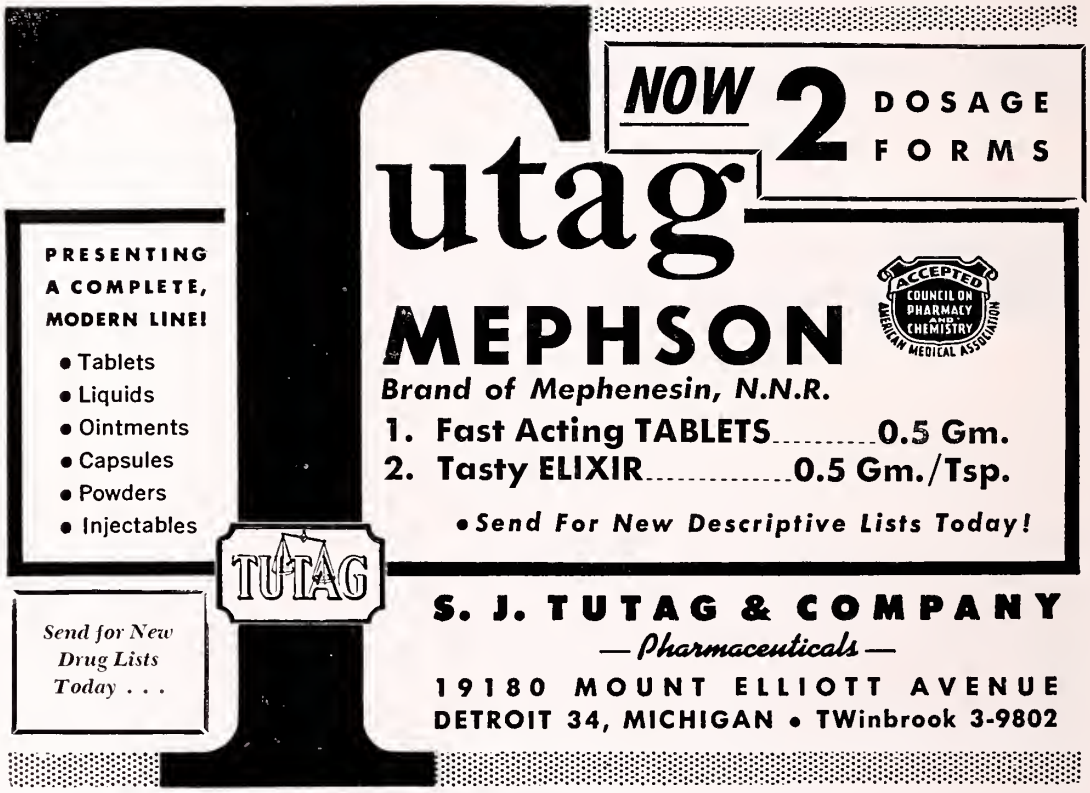


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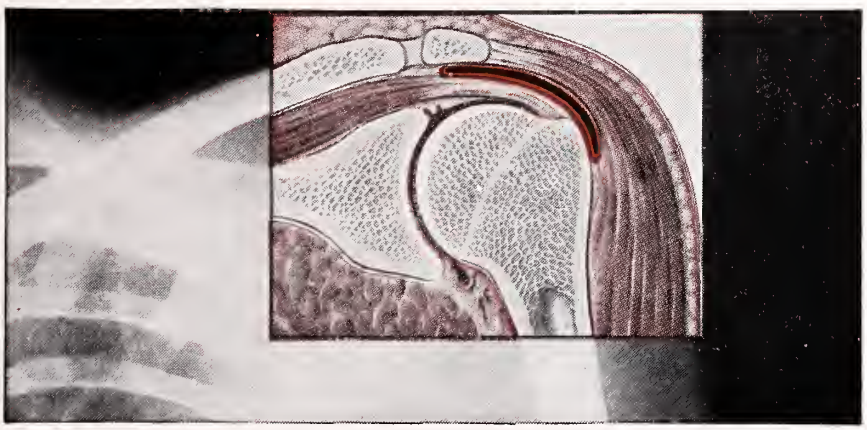
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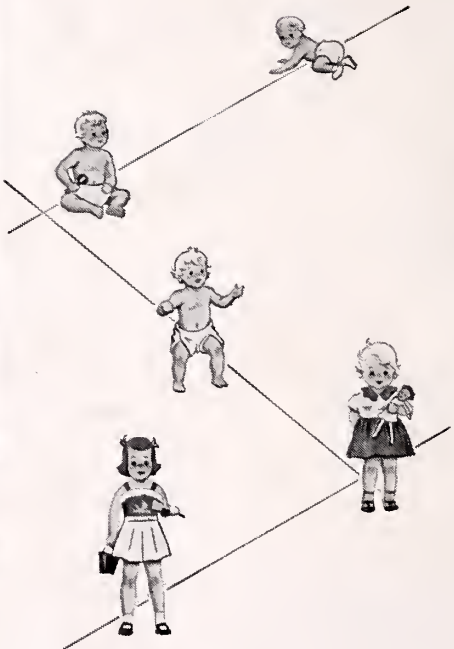
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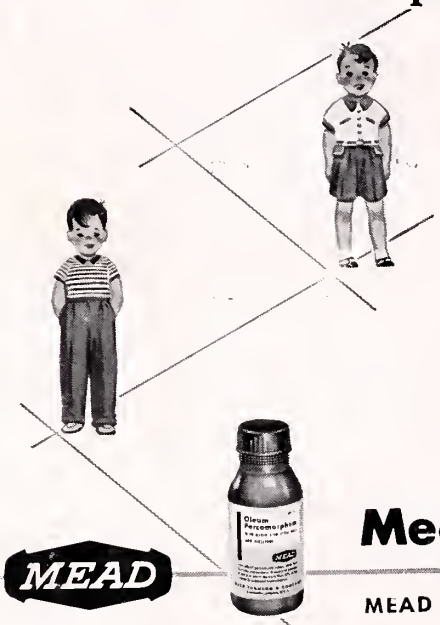
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**Turn to Page 206**

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VOL. 50 FEBRUARY, 1928

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[CONTRIBUTION FROM THE RESEARCH LABORATORIES OF PARKE, DAVIS AND CO.]

# THE ACTIVE PRINCIPLES OF THE POSTERIOR LOBE OF THE PITUITARY GLAND.[1] I. THE DEMONSTRATION OF THE PRESENCE OF TWO ACTIVE PRINCIPLES. II. THE SEPARATION OF THE TWO PRINCIPLES AND THEIR CONCENTRATION IN THE FORM OF POTENT SOLID PREPARATIONS

BY OLIVER KAMM, T. B. ALDRICH, I. W. GROTE, L. W. ROWE AND E. P. BUGBEE

RECEIVED DECEMBER 31, 1927 PUBLISHED FEBRUARY 4, 1928

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Volume 13
Number 3

JANUARY-FEBRUARY, 1954

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Honolulu, Hawaii, U.S.A.

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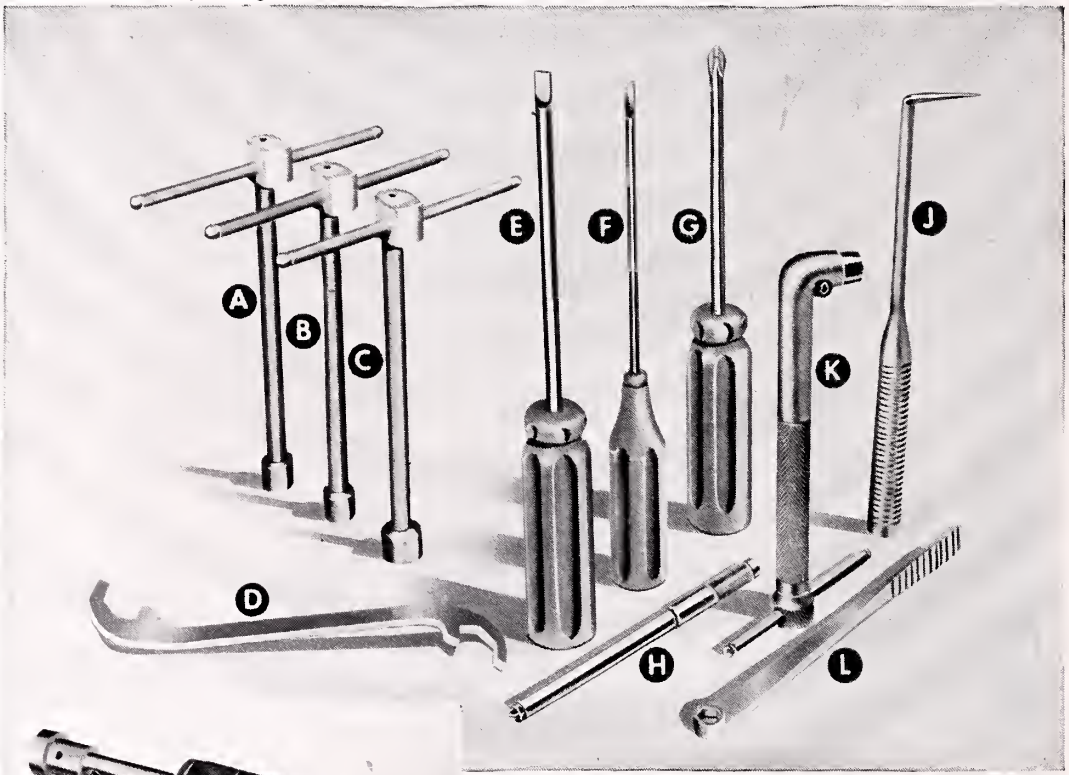
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**JANUARY-FEBRUARY, 1954**

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## HOSPITALS

### Children's
Monday—12:30 P.M.—weekly luncheon—case reports
Friday—12:30 P.M.—monthly staff luncheon and meeting—4th Friday

### Kapiolani
Tuesday—12:30 P.M.—weekly Ob. and Gyn. seminar under Dr. K. S. Tom
Thursday—12:30 P.M.—monthly staff—3rd Thursday

### Kuakini
Friday—5:15 P.M.—monthly
Dinner and staff meeting—2nd Friday

### Leahi
Friday—7:30 P.M.—monthly
Sinclair Club (For study of chest diseases) 2nd Friday

### Queen's
Thursday—12:30 P.M.—monthly
Staff meeting and luncheon—last Thursday

### St. Francis
Wednesday—7:30 P.M.—monthly
Ob. and Gyn. Statistical meeting—2nd Wednesday
Thursday—12:30 P.M.—monthly
Clinical Pathological Conference—4th Thursday
Friday—12:30 P.M.—monthly
Staff meeting and luncheon—3rd Friday

## TUMOR CLINICS

### Kuakini Hospital
Monthly—1st Tuesday—1:00 P.M.

### Queen's Hospital
Monthly—1st and 3rd Manday—4:15 P.M.

### St. Francis Hospital
Monthly—2nd Tuesday—12:30 P.M. under Dr. R. B. Chappell
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## SOCIETIES

### Honolulu County Medical Society
Monthly meeting—1st Friday—7:30 P.M.
Board of Governors—Tuesday of week preceding above—4:15

### Honolulu Academy of General Practice
Monthly—7:30 P.M.
Pres.—Dr. Robert F. Bailey Sec.-Treas.—Dr. Homer R. Benson

### Hawaii Dermatological Society
Saturday, February 6—1:00 P.M.
Pres.—Dr. H. M. Johnson Sec.-Treas.—Dr. H. L. Arnold, Jr.

### Honolulu Eye, Ear, Nose & Throat Society
3rd Thursday—monthly—6:30 P.M.
Pres.—Dr. Tadao Hata Sec.-Treas.—Dr. Albert K. T. Ho

### Honolulu Obstetrical & Gynecological Society
3rd Monday—monthly—7:30 P.M.
Pres.—Dr. Satoru Nishijima Sec.-Treas.—James T. S. Wong

### Honolulu Orthopedic Society
4th or last Thursday—monthly—7:30 P.M.
Pres.—Dr. John W. Cooper Sec.-Treas.—Dr. Richard S. Dodge

### Honolulu Pediatrics Society
3rd Thursday—monthly (closed)
Pres.—Dr. John H. Peyton Sec.-Treas.—Dr. Harold M. Sexton

### Honolulu Surgical Society
3rd Friday—alternate months (Jan., Mar., May, etc.)—7:30 P.M.
Pres.—Dr. Lester Yee Sec.-Treas.—Dr. Verne C. Waite

### Hawaii Medical Association
May 13-16, 1954—Mabel Smyth Building, Honolulu

### Territorial Ass'n of Plantation Physicians
Meets during the 6th Congress of Pan-Pacific Surgical Ass'n—October 7-18, 1954, in Hanolulu
Pres.—Dr. Garton E. Wall Sec.-Treas.—Dr. H. M. Chandler

### Hawaii Chapt., Am. Clge. of Chest Physicians
Meets at announced dates
Pres.—Dr. Hastings H. Walker Sec.-Treas.—Dr. F. L. Giles

### Hawaii Chapter, Am. College of Physicians
Meets at announced dates—quarterly
Pres.—Dr. Nils P. Larsen

### Hawaii Chapter, Am. College of Surgeons
Meets at announced dates
Pres.—Dr. R. O. Brown Sec.-Treas.—Dr. F. J. Pinkerton

### Pan-Pacific Surgical Association
6th Cangress meets October 7-18, 1954, in Honolulu
Pres.—Dr. I. S. Ravdin, Philadelphia
Dir.-Gen.—Dr. F. J. Pinkerton

### Society of Neurology & Psychiatry of Hawaii
Monthly—2nd Wednesday—7:30 P.M.
Pres.—Dr. John G. Lynn Sec.-Treas.—Dr. Yan Tim Wong

### Radiological Society of Hawaii
Manthly—3rd Friday—place as announced
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### New Orleans Graduate Medical Assembly
Postclinical Taur to Hawaii—March 14 to April 1
Scientific meeting March 29

### A.M.A. Postconvention Tour to Hawaii
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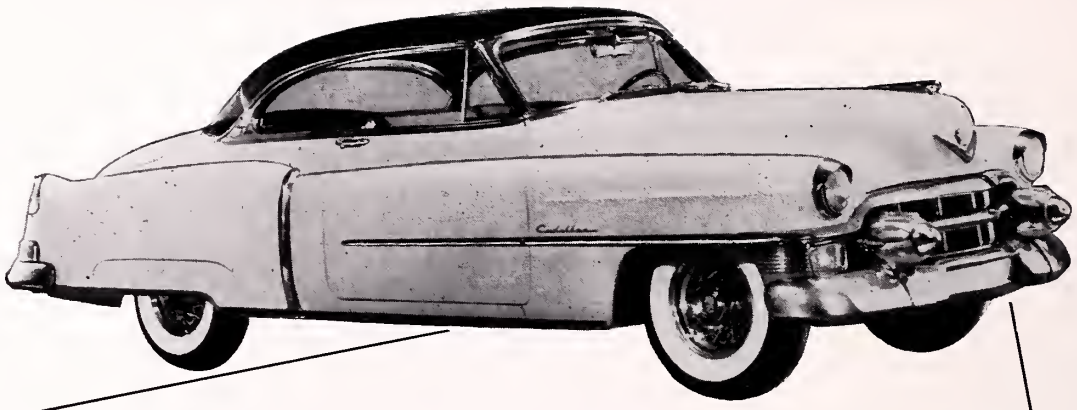
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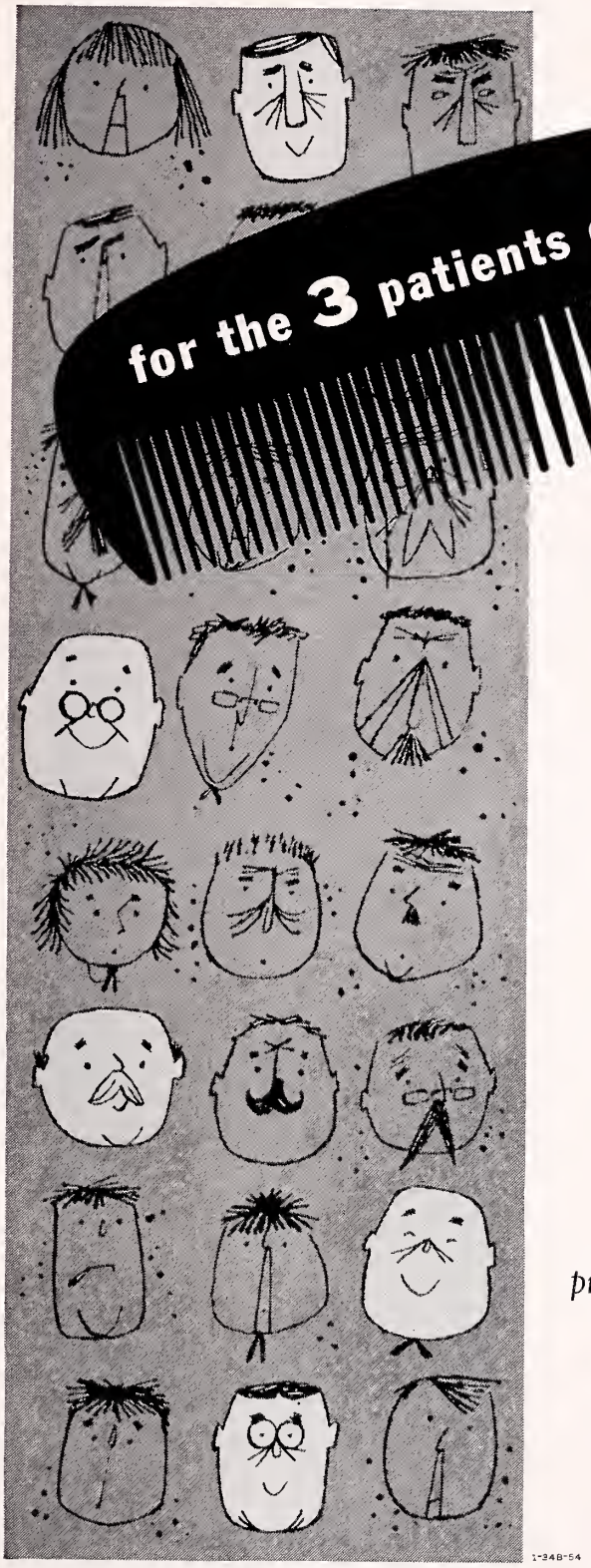
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1. Slepyan, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), *ibid.*, 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

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1. Trafton, H. M., and Lind, H. E.: J. Urol. 69:315 (Feb.) 1953.
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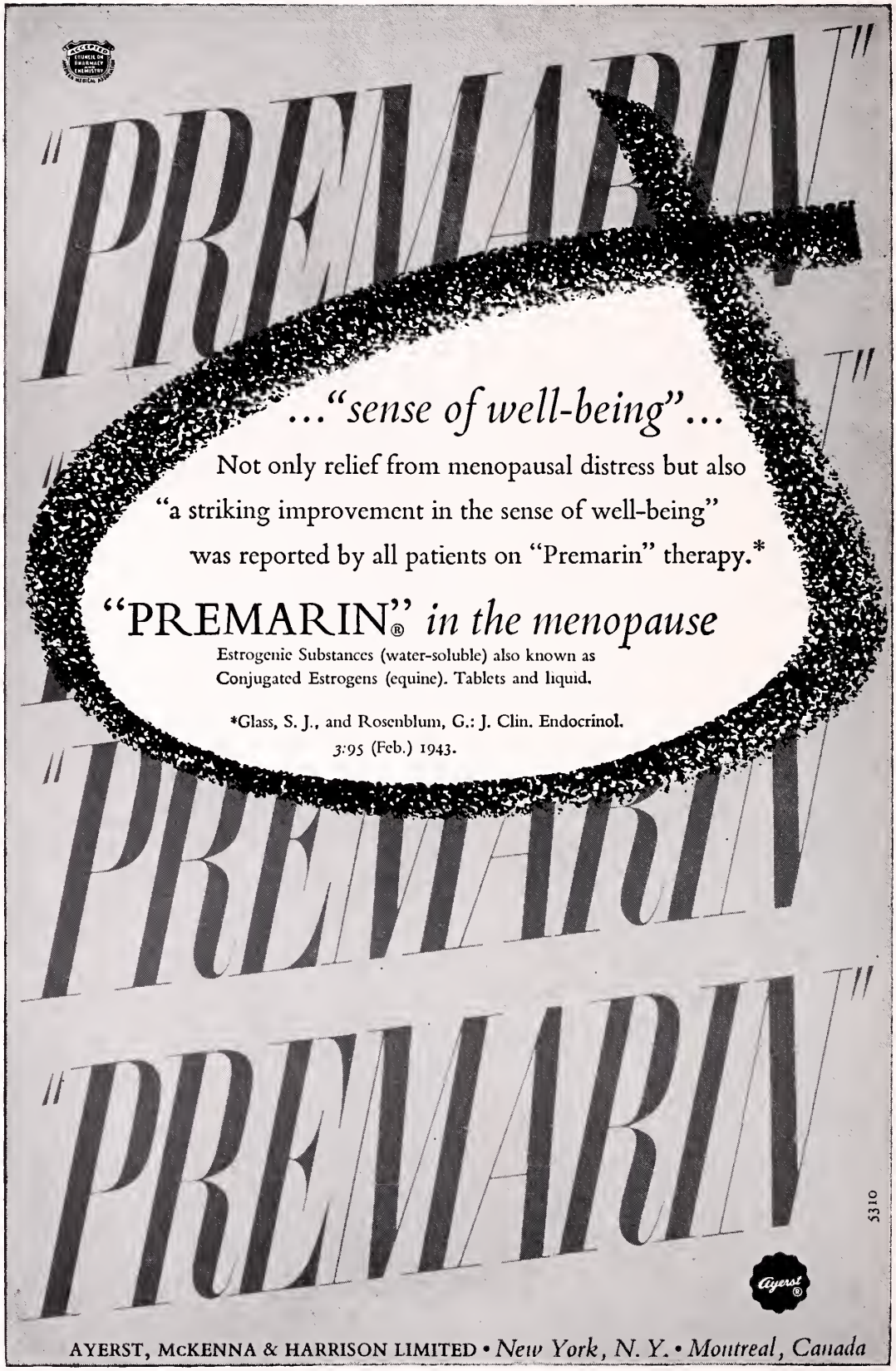


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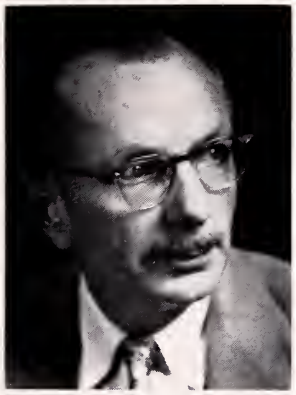
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# KONA WEATHER AND THE INCIDENCE OF ASTHMA IN CHILDREN IN HONOLULU

W. A. MYERS, M.D.* AND SAUL PRICE, M.S.†
HONOLULU

If it is ever true that one should consider the whole patient, including his environment, in the treatment of a disease, then the treatment of an asthmatic is a perfect example of this truth. For it is certain that the more the physician knows about his allergic patient's total environment, in the broadest sense of the word, the more successful he will be in treating him. Therefore, it is important for the physician to evaluate for each attack of asthma the relative importance of all etiologic factors. Otherwise, he may blame the weather, let us say, instead of the neighbor's cat, for Jimmy's wheezing.



DR. MYERS

## The Present Problem

In Hawaii, so-called "Kona weather" is accepted by many physicians and patients as a "cause" of attacks of asthma. While that belief is based on wide experience, its validity has not yet been subjected to either experiment or objective analysis. The present report describes a preliminary attempt to provide the latter by ascertaining the influence of certain gross weather types on the incidence of the onset of asthma among children in Honolulu. It does not try to examine the relation of that incidence to specific weather elements or combinations of them, or to the changeableness of the weather, nor to explore in many other interesting and possibly fruitful directions. Not that these were discounted,—quite the contrary, as this paper hopes to show—but rather that the concern here was with a different hypothesis: that the atmospheric complex called Kona weather induces among Honolulu children a disproportionate number of asthmatic attacks.

During the course of the investigation, a number of questions arose regarding the methodology and the interpretation of data and results, as well as what might be called the philosophy of the problem. Some of these were peculiar to the present study, while others appeared to have wider implications. We believe they are relevant and will consider them briefly in this report.

## Weather and Climate of the Hawaiian Islands

### *The Broad-Scale Regime*

Those experiments already described on weather effects on asthma, as well as most other similar studies, have been made in localities in which are commonly found weather, and changes in weather, of a kind rare or wholly unknown in Hawaii.

In such a city as Chicago, for example, to choose one which has been the site of some of the best-known experiments, the passing of a cold front, replacing by an air mass of polar or arctic origin one born nearer the tropics, may within a very few hours or even a single hour completely transform the prevailing climatic environment. Temperature falls of 20 or 30° F., rapid declines and rises in barometric pressure of several tenths of an inch, sudden wind squalls with snow or chilling rain, wide fluctuations in the relative humidity—such dramatic events, far exceeding what is ever encountered in these peaceful isles, are during a large part of the year the common, not the extraordinary, accompaniments of a cold frontal passage. Many convey even more extreme weather changes than these to most of the mainland. Conversely, much of that area suffers during the warmer season such stifling and protracted spells of heat and humidity as not even the worst Kona weather brings.

In Hawaii, surrounded as it is by thousands of miles of open ocean, the oncoming winds from every quarter and in every season are brought near a common equableness foreign to continental regions. The "normal" or customary weather is that which accompanies the trade winds. These, whose usual direction is from a little north of east, derive their name from their constancy, that is from their being always on course or "trade." Their source is the large region of relatively high atmospheric pressure (the semi-permanent Pacific high, or anticyclone) usually situated about a thousand miles north or northeast of Hawaii,

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which engenders the trades along its southerly flank. In traversing the intervening temperate ocean, these winds acquire that moderation in heat and moisture to which the islands owe their justly renowned climate.

At times, as the parent anticyclone becomes less intense or moves away, the trades weaken or disappear. In their stead then occur gentler air movements, induced principally by temperature differences between the land and the surrounding sea, or a steadier southerly current from a cyclonic (counterclockwise) wind system somewhere to the south or west. Both these alternatives to the trades (they are not the only, but the more usual ones) give rise to weather quite different from that which they replace.

The cyclonic systems, called Kona storms by local meteorologists, bring to the Hawaiian Islands southerly streams of warm, moist tropical air. The steady, widespread rain which often accompanies them increases the humidity, and the clouds reduce solar heating. Consequently, there is little diurnal variation in temperature, relative humidity, or wind.

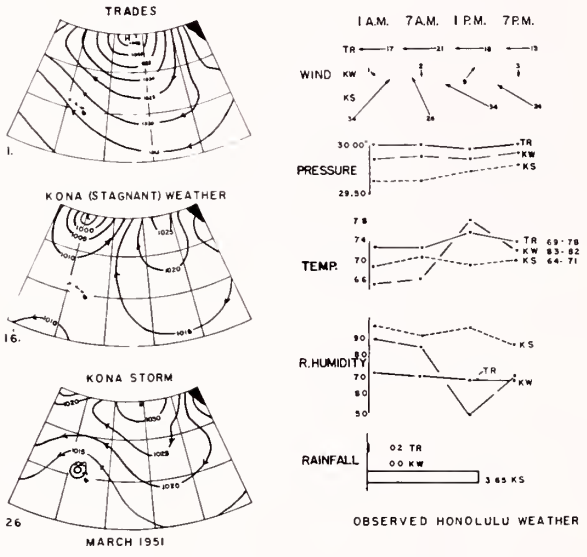



FIG. 1. Three types of air flow in Hawaii.

Kona storms rarely affect local weather directly for more than two or three days. They are, however, often preceded and followed by longer intervals during which the absence of a general wind induces conditions of sometimes oppressive stagnancy. During the day the rising of air heated over the land and mountains induces an on-shore drift (sea-breeze) from the relatively cool ocean; at night, radiational cooling reverses the flow. The movement of air is gentle and in many places imperceptible. Showers are infrequent and local. With the passing of time, the air increasingly acquires through heating and evaporation the unpleasant properties of the tropical atmosphere. Days are sultry, the nights—due to the lessened cloudiness—cooler than usual. This is the "Kona weather" of ill repute. It may last a day or persist for a week or more.*

These three highly important types of air flow in the Hawaiian area are illustrated in Figure 1 by sections from actual weather maps of March, 1951. (The same month was used for all three to demonstrate that the differences are not seasonal.) The accompanying observations of wind, temperature, relative humidity, pressure, and rainfall were made those same days at the Honolulu Weather Bureau's Airport Station.

Note particularly, among the items already referred to, the larger diurnal changes (including the land and sea breezes) characteristic of Kona weather; the small ones of the Kona storm; and the latter's heavy rainfall, high humidities, and moderate temperatures. They confirm what was suggested earlier, that the differences among weather types are not superficial (i.e., the mere "appearance" of a map) but imply basic distinctions in the entire weather complex.

These are, of course, only examples. Each weather map and each day of weather is unique. The transition from one to another of these atmospheric states is usually a gradual one. Even the most extreme, however, produces—in all the weather elements but rainfall—changes mild indeed as compared with those which in more northerly latitudes commonly accompany even a modest cold front passage.

### *Local Influences*

But while day-to-day modifications in the weather are thus being tempered by the uniform properties of the embracing ocean, the mountainous terrain of the islands disrupts this prevailing homogeneity into a variety of disparate climates, so that, quite often, adjoining heights and valleys of Honolulu have very different weather.

These local differences lie in the frequency and amount of rainfall, the temperature and its daily range, the relative humidity, the wind, the barometric pressure, and the amount of cloudiness or sunshine—that is, in all the weather elements usually regarded as bearing on man's well-being.

* "Kona," in the Hawaiian, denotes the southerly or leeward direction, with a secondary connotation of sick wind. Although the point is not certain, it appears likely that the Hawaiians meant by it the storm rather than the stagnant conditions described above. The modern meteorologist also prefers this meaning.

Of these, only rainfall is regularly gaged at a large number of sites (about forty) within and around the city; temperature and relative humidity at a few, and the others only at Honolulu Airport, a location somewhat removed from any populated center.

Figure 2 shows the average annual rainfall for Honolulu as determined from the indicated reporting gages. Note that only a few miles separate the semi-arid beaches from the tropical rainforest of the upper residential valleys.

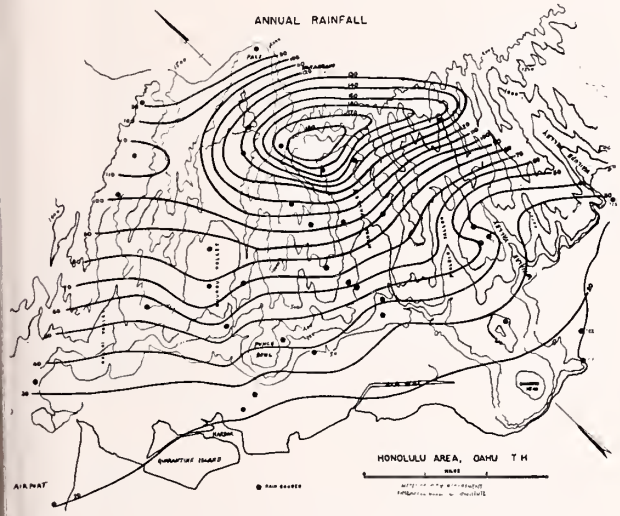



FIG. 2. Variation of annual rainfall in Honolulu.

Rainfall differs widely within short distances, not only in its total amount, but also in its distribution through the year. In Figure 3 may be seen the proportion of the year's rainfall received in each average month by several residential neighborhoods. The drier areas, like Black Point and downtown Honolulu, are much rainier in winter than in summer, while the wetter sections get about as much in one season as in another.

Were similarly detailed data available for the other weather elements, they would be seen to vary as widely. For example, Mount Tantalus is, on the whole, cooler in July than is the business district in January. As for barometric pressure, so often suspected of complicity in illnesses of various sorts, that element changes so quickly with elevation that anyone driving between the residential heights and the lower city encounters within a few minutes greater and more rapid rises or falls than ever occur at any one elevation in the Islands.

### *Diurnal Factors*

In addition to these differences from place to place, some of the more important weather elements exhibit average daily changes equal to or greater than their changes from one general weather type to another. Thus the daily curve of

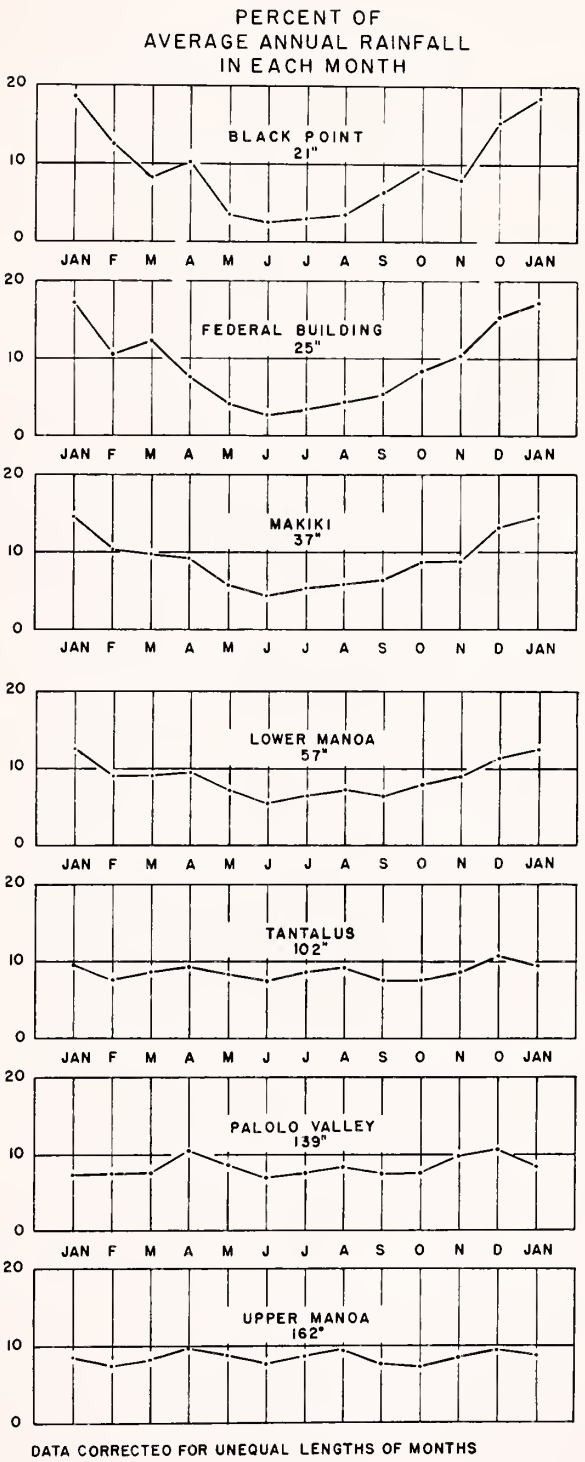



FIG. 3. Per cent of average annual rainfall in each month in various localities in Honolulu. Note gradual disappearance of summer "dry spell" as graphs progress from Black Point, a leeward area near Diamond Head, northward into the mountain area.

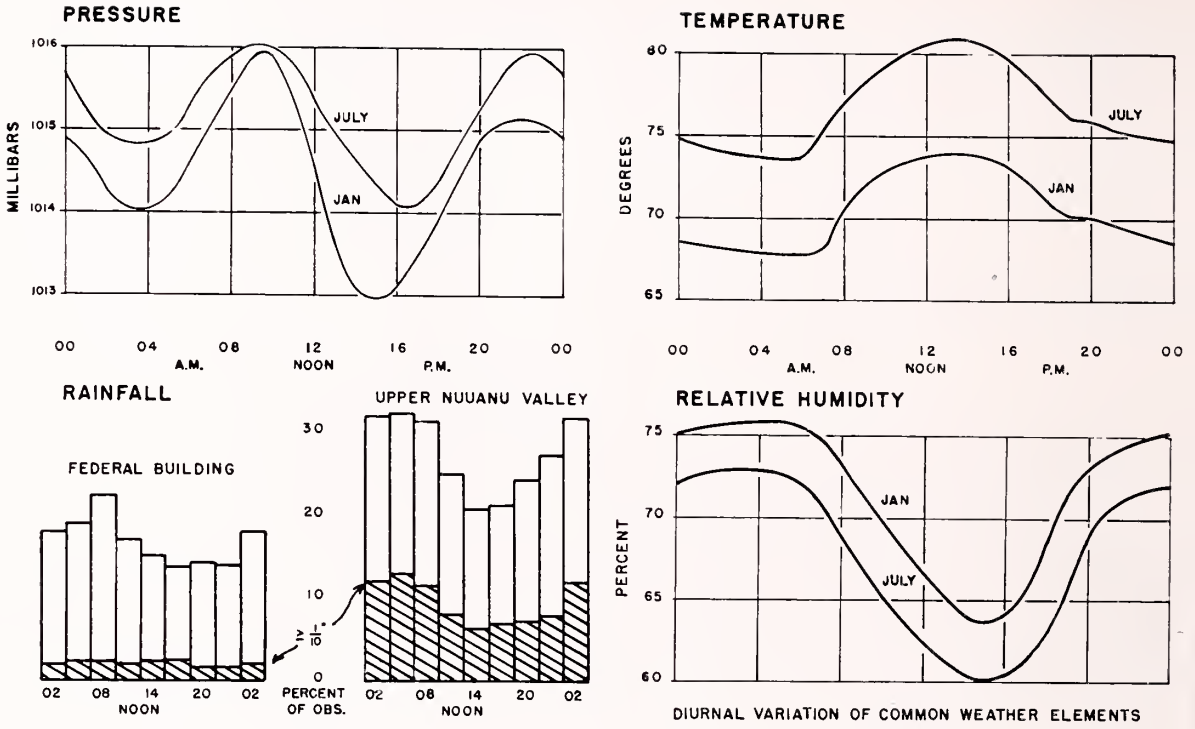



FIG. 4. Daily variations in barometric pressure, temperature, rainfall and relative humidity in Honolulu.

atmospheric pressure (Fig. 4) has an amplitude of three millibars—about three parts in a thousand—ten times that for Chicago, but only one-tenth of what that city frequently experiences within just a few hours with the passing of a cold front. (A fall of three millibars is equivalent near sea level to an ascent of only one hundred feet. The total range of sea-level pressure extremes ever recorded in Hawaii is roughly equivalent to the pressure difference between Waikiki and Tantalus.)

The diurnal range of temperature for downtown Honolulu about equals the seasonal. Relative humidity, being inversely dependent on temperature, possesses a similar variation. Rainfall is most frequent during the night time and early morning hours.

What it comes to is this: on the mainland, the greatest weather contrasts occur abruptly and intermittently—usually when one air mass replaces another; in Hawaii, they are often to be encountered simply by moving about or by letting the day take its course. Thus a child who lives in Diamond Head or Waikiki and spends the weekend with her aunt in upper Manoa or Nuuanu Valley undergoes a greater change in almost every element than she might have experienced in a long while had she remained where she was. A realistic appraisal of the weather-asthma relationship, for a particular patient in whom it was suspected of operating, would therefore in such a locale as Honolulu require taking into account not only where he resided, but his goings and comings as well. To the physician concerned with the etiology of a particular asthmatic attack, this places weather in the same category as the other environmental influences—diet, vegetation, pets, or bedclothes—which might also change as one moved about.

## A Few Difficulties

A complete recital of the complications latent in what may superficially appear to be a simple problem in statistics—relating allergy to weather—would cause this paper to deviate too far from its main theme. But neither is it proper to omit all mention of them—although what has gone before may at least have suggested the character of some.

While Hawaiian weather varies within much narrower limits than the mainland's, it may be that local residents through acclimatization have grown as sensitive to those subtler vagaries as mainlanders to their more violent ones. This would make it more pertinent that few of the diurnal and sectional differences, whose importance in Honolulu's weather has been described, are adequately measured, since to do so would require a far

denser network of meteorological instruments than now exists. The implications are obvious: if these unevaluated distinctions in climatic environment are of consequence to the patient, the likelihood of uncovering the weather influence in his illness from existent data is considerably diminished.

About asthma itself, much is unknown. If on different occasions the same individual responds similarly to different weather factors or differently to the same weather factors, the relation may be almost impossible to extricate from other predisposing influences. Differences in lag among asthmatic children in their response to a weather stimulus may blunt the onset-incidence peaks or defer them to succeeding periods of non-causative weather. Since reactive lags are usually of the order of hours—less, almost certainly, than those between the attack and the patient's visit to his physician—the effect is probably a small one. Similarly, once begun, an attack may persist into other weather situations unlikely in themselves to have given rise to it. (This, however, would not affect the present investigation, which deals only with times of onset.) Nor can it be overlooked that many attacks are neither seen by the physician at the time they occur, nor referred to by the patient in later visits. It is evident that the interview and case history can scarcely err on the side of completeness.

Thus the most fundamental and irresolvable difficulties are seen to lie in the very natures of allergy and weather. Both are not single entities but complex phenomena to which deceptively simple names have been given. Into the diagnosis and measurement of each, subjectivity enters; especially in allergy, the hypothesis of the observer contributes to what he discerns in the patient's symptoms. The data through which a relationship is to be sought between these two poorly defined and highly complicated variables is obtained not from the animate actuality, but culled from the past record, incomplete, and usually compiled with quite other ends in mind.

In all, statistical difficulties inextricably entwined with those derived from our incomplete understanding of the asthmatic reaction produce data whose inadequacy threatens to obscure or distort whatever correlations exist.

### The Asthma Onset-Incidence

For the past five years the Pediatrics Department of the Straub Clinic in Honolulu has been recording each day the number of *onsets* of asthmatic attacks among the children seen by them.

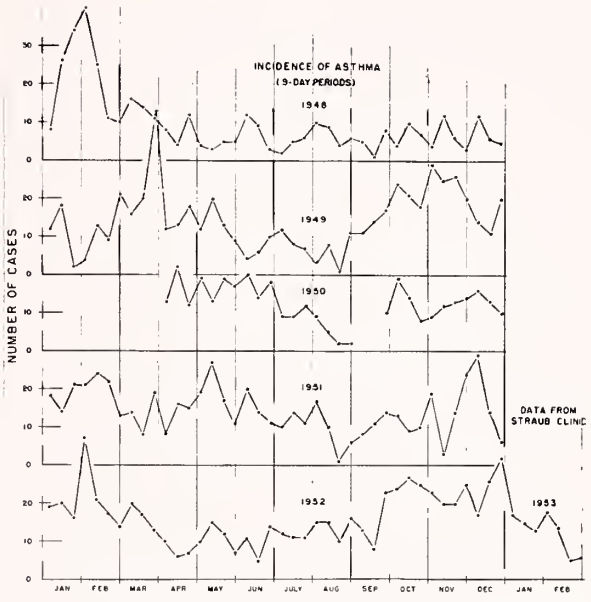



FIG. 5. Incidence of asthmatic attacks in children seen at the Straub Clinic, Pediatric Department. The onset dates are plotted for nine-day periods from January, 1948, to February, 1953.

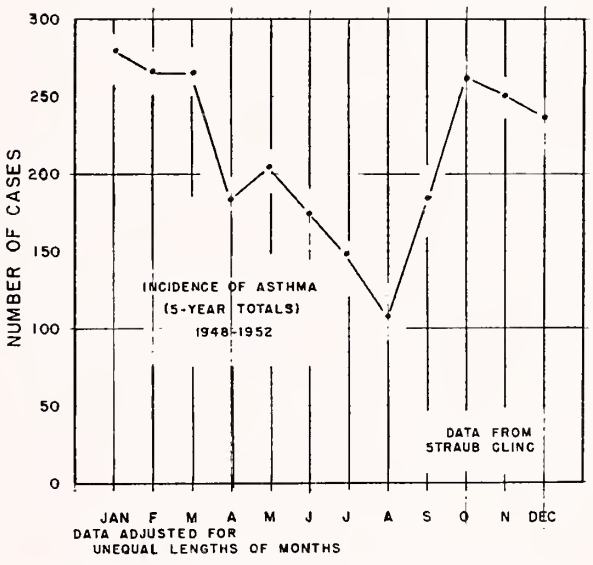



FIG. 6. Incidence of asthmatic attacks for five years, shown in Fig. 5, combined to show seasonal variation.

This incidence was found to vary from none to ten per day. In Figure 5 the number of onsets has been plotted for nine-day periods from January, 1948, through February, 1953. The only prominent feature which appears consistently from year to year is the relatively low summer incidence. When years are combined and months adjusted to uniform lengths, the seasonal variation becomes that of Figure 6.

So marked an annual cycle calls for explanation. Its peaks correspond roughly to the blooming time of Bermuda grass and sugar cane, but not to that of any of the common trees and shrubs. It is, in fact, the opinion of several Honolulu allergists who have made survey counts that pollen is not an important factor here, except on occasion and very locally. Mold spore densities, also, are lower than in most mainland localities. Vegetation, then, seems to be ruled out as a cause of the seasonal variation. Rowe[9] describes this type of seasonal incidence as one of the typical characteristics of food allergy. He believes that "the increased available solar radiant energy best explains the beneficial effect of the summer months." This explanation, however, is not acceptable in Hawaii, since there is so little seasonal variation in available sunshine.

During 1952, the incidences of asthmatic and respiratory infection cases admitted to the Kauikeolani Children's Hospital of Honolulu corresponded so closely that data for the earlier years were obtained and examined. Figure 7 reveals, however, that—except for the general trend—the correspondence does not hold well through the longer period.

One encounters no similar lack in the weather of elements which can be so expressed as to disclose seasonal variations like those of Figure 6. For example, the frequency through the year of days with low temperatures or light winds or high humidities would do so, as would—more significantly—the seasonal frequency in Kona storms which only rarely occur in the summer.

### Delineation of the Weather Types

Whenever two quantities vary together, and one may reasonably be ascribed in whole or part to the other, it can be a difficult matter indeed to test the point and separate coincidence from causality. So with these concomitant variations in asthma incidence and various weather factors.

It has already been made plain that the concern of the authors here was not with the minutiae of the weather but rather with its more readily definable broader aspects, and the responsiveness to these of the onset-incidence of asthmatic attacks among children in Honolulu.

To attack the problem in these terms it was necessary to resort to an artifice: that is, to describe the atmosphere, which is a continuum in time and space, as though it existed in various discrete states. This method, known to meteorologists as "typing," is particularly appropriate to such an investigation as this, provided that its limitations and assumptions are kept in mind in interpreting the results. What needed to be done was first, to define by appropriate criteria Kona weather and the other weather "types" which influence Hawaii, then to identify and classify accordingly the days of the period of record, and finally to determine whether statistically significant differences in the onset-incidence of asthma appeared between them. Since the intent was to distinguish the stagnant Kona condition from others differing from it primarily in the degree of ventilation, the chief criteria were in terms of the average strength and prevailing direction of the wind. These were set forth not with complete rigor, but rather in such terms as would lead to little difference of opinion among experienced meteorologists. Further details, possibly of more interest to meteorologists than to physicians, may be found in the footnote.*

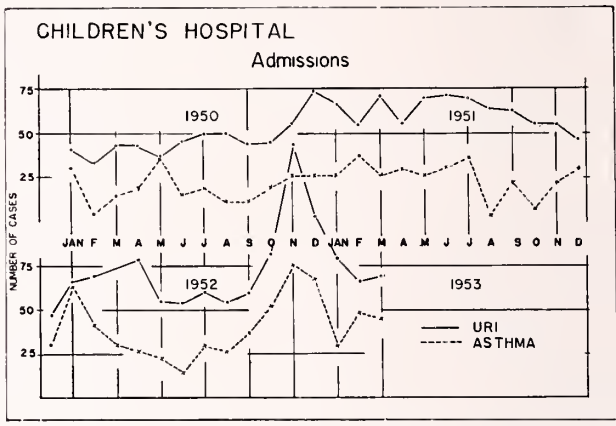



FIG. 7. Monthly incidence of asthma and respiratory infection cases admitted to the Children's Hospital of Honolulu. Note apparent correlation between the number of asthma and respiratory infection cases in 1952-53, and the very little correlation in 1950-51.

From the meteorological charts and records on file at the U. S. Weather Bureau's Honolulu office, each day from January, 1951, to February, 1953, was classified as belonging to one of five types, ranging from strong through moderate and light trade winds to intermittent Kona weather and Kona weather (See again Fig. 1).

* 1. *Strong trade winds:* easterly winds persisting throughout the twenty-four hours, with speeds in each hour of 12 miles per hour or more;
2. *Moderate trade winds:* as above, but with easterly winds as low as 8 miles per hour at times;
3. *Light trade winds:* easterly winds during all but the few hours of lowest speed;
4. *Intermittent Kona weather:* light winds varying from trade to occasional land and sea breezes;
5. *Kona weather:* the unmistakable regime of land and sea breezes, high temperatures and humidities, etc.

It has already been shown (Fig. 1) that not only does the general pattern differ among types, but that the average values of the individual elements also tend to do so.

Kona storms were few during the period studied. They were first examined individually and then placed in type 4, intermittent Kona weather, when no discernible difference appeared in the onset incidence.

## Weather-Asthma Relationships

### *Onset-Incidence of Asthma*

There were during the period January, 1951, to February, 1953, 1259 individual asthmatic onsets distributed over 754 meteorologically classifiable days. Table 1 gives the number of days and periods each weather type occurred, the average length of the latter, the number of asthma onsets, and the average incidence for each type.

TABLE 1.—*Relation of Onset-Incidence of Asthma to the Prevailing Weather Type.*

| A | B | C | D | E | | F |
|---|---|---|---|---|---|---|
| Weather Type | No. of Periods | No. of Days | Average Length of Periods, Days | Number of Asthma Onsets | | Average Incidence Cases per 100 Days |
| 1. Strong Trades | 5 | 62 | 12.4 | 85† | 103‡ | 137 |
| 2. Moderate Trades | 15 | 174 | 11.6 | 299† | 291‡ | 172 |
| 3. Light Trades | 22 | 240 | 10.9 | 392† | 400‡ | 163 |
| 4. Intermittent Kona Weather | 18 | 138 | 7.7 | 207† | 231‡ | 150 |
| 5. Kona Weather | 18 | 140 | 7.8 | 276† | 234‡ | 197 |
| | | 754 | | 1,259† | Avg. | 167 |

† Observed.
‡ Expected.

The incidence, it will be noted, was greater during Kona weather (Type 5) than at other times, but not what most persons might consider strikingly so. However, the statistical probability that differences of the magnitude shown on the one hand, between the onset-incidence during Kona weather (5) and all other types combined, and, on the other, between each group and its expectancy, were due solely to chance, was estimated (by Chi-Square) to be about one in one hundred, a probability so low as to be generally regarded as highly significant.*

The differences between incidences within Types 2 and 5, Moderate Trades and Kona Weather, are not, considered by themselves, statistically significant ($P=0.10$).

Such tests offer not proof but evidence, and a finite probability always remains that coincidence produced the observed differences. This result then suggests that, on the whole, an attack of asthma is more likely to begin during Kona weather than during any other time. It must, however, be kept in mind that "Kona weather" and "any other time" refer only to the weather types as used here. By choosing different specifications, one might isolate weather conditions in which the onset-incidence exceeded that for Kona weather as here defined.

* Since Kona weather (5) was present on 140 of 754 days, we might expect 140/754 (about 18.6%) of the 1,259 asthma onsets, or 234 cases, to have occurred during Kona weather, *if no weather influence was operating*. Actually, the incidence was 276. Chi-Square is a method of estimating the likelihood that differences as large as those observed between the actual and "expected" numbers of cases could occur by chance alone; that is, of arriving at a probability that weather *was* affecting the onset incidence. Adjusted expectancies were used.

### *Peaks and Sharp Rises in the Asthma Incidence*

Those days were then selected on which sharp increases or peaks in the incidence of asthma had occurred, and the number which might by chance alone have been expected to fall into each weather type compared with that which actually did so. The results are shown in Table 2.

TABLE 2.—*Incidence of Peaks or Sharp Rises in the Onset of Asthma as a Function of the Prevailing Weather Type.*

| A | B | C | D | E |
|---|---|---|---|---|
| | NUMBER OF PEAKS OR SHARP RISES IN THE ASTHMA-ONSET INCIDENCE | | | |
| WEATHER TYPE | OCCURRED | EXPECTED | CASES/DAYS | AVERAGE INCIDENCES CASES/100 DAYS |
| 1. Strong Trades | 5 | 4.9 | 45/17 | 265 |
| 2. Moderate Trades | 15 | 13.6 | 204/72 | 283 |
| 3. Light Trades | 18 | 18.8 | 256/89 | 288 |
| 4. Intermittent Kona Weather | 13 | 10.8 | 203/68 | 299 |
| 5. Kona Weather | 8 | 11.0 | 145/48 | 302 |

Most worth noting from Table 2 is that, except for Types 4 and 5, the differences between the expected and observed values are relatively small. It was, therefore, not surprising to find that in contrast to those of Table 1, for which only 1 per cent probability of chance was found, the corresponding likelihood that the discrepancies of Table 2 are due to chance alone is about 90 per cent. This means that, on the whole, there is no apparent weather effect on the incidence of sharp rises and peaks. Why for Kona weather, in which the opposite relation might have been anticipated, fewer peaks were observed (8) than expected (11) can only be attributed to the vagaries of chance. An especially interesting result is that of Column E, in which the average incidence during peak periods appears to increase slowly as the degree of air movement diminishes.

### *Days on Which One or More Attacks of Asthma Began*

TABLE 3.—*Days with One or More Onsets of Asthma (January, 1952, to February, 1953, only).**

| A | B | C | D | E |
|---|---|---|---|---|
| | | NUMBER OF DAYS WITH ASTHMA ONSETS | | |
| WEATHER TYPE | NUMBER OF DAYS | OBSERVED | EXPECTED | PERCENT OF DAYS WITH ASTHMA ONSETS |
| 1. Strong Trades | 66 | 48 | 50 | 82.7 |
| 2. Moderate Trades | 147 | 112 | 111 | 86.2 |
| 3. Light Trades | 102 | 76 | 77 | 84.5 |
| 4. Intermittent Kona Weather<br>5. Kona Weather | 98 | 76 | 74 | 88.6 |

* To avoid a lengthy re-tabulation of the data only this fourteen-month period was used. It is unlikely that the results differ greatly from what the longer record would have shown.

We compared now (for each weather type) the number of days on which one or more attacks of asthma had begun, with the number expected by chance. The differences as shown by Table 3 are trivial, although Kona weather again displays a slight, but statistically insignificant, excess.

Finally, from among the case histories of asthmatic children seen by the Pediatric Department of the Straub Clinic, 26 of particular completeness were selected and the days on which each child's asthmatic attacks had begun classified individually according to weather type. In no instance was an invariable association found, and in most no relation at all could be discerned.

## Comments and Conclusions

The method used here was a gross one, designed to detect gross relationships. It did not attempt to assess the influence of the minutiae in the weather and could not have done so. Rather, we have tried to point out some of the difficulties imposed upon such an attempt by present limitations in our knowledge and observations, and by the local vagaries of the weather.

It was hardly to be anticipated that Kona weather would emerge as a necessary and sufficient concomitant of asthmatic attacks. However, in view of the widespread local belief in their relationship, some positive correlation was expected.

Actually, the results obtained are neither negative nor incontrovertibly positive. They seem, more than anything, to confirm the complexity of the problem. Periods of low, as well as high, onset incidence have occurred during Kona weather, but also with trade winds. One of the highest onset peaks, that of December, 1952 (21 cases in five days), was, in fact, reached during an extended period of strong trades (Type 1). On the whole, attacks of asthma appear slightly more likely to begin during Kona weather than at other times; but this difference, while satistically significant, is small.

Although no study was explicitly made of the effect of weather changeability, it was apparent that no more than a faint relation could be present. January, 1953, the most variable of the months in its continual shift from one weather type to another, had an onset incidence of 170 cases per 100 days. Comparing this with the entries in Column F of Table 1 shows it to be no higher than average.

## Summary

1. There is on the average, among children in Honolulu, a definite maximum in the incidence of the onset of asthma during the period October to May, with the yearly peak in January, February and March.

2. There is some suggestion that respiratory infection may at times be a predisposing factor in the asthmatic reaction.

3. On the whole, from a study of 1259 asthma cases during the period January, 1951, to February, 1953, the onset-incidence appears to be a little greater during Kona weather than at other times. The difference, while statistically significant according to the criterion used, is small.

4. Sharp rises or peaks in the incidence of asthmatic attacks, and days free from asthma onsets, are relatively no more (or less) frequent during Kona weather than at other times.

5. In none of 26 asthmatic children whose case histories were studied in detail, did Kona weather or any other weather type invariably precede the attacks. In most cases only a chance relationship appeared to exist between an attack and the concurrent or preceding weather.

What must be borne in mind in evaluating these results and conclusions is that they apply strictly only to the particular way in which allergy and the weather were herein defined and the connection between them sought. It would be unwarranted to infer from them that such a relation would not be found were a different approach to be taken—or that it would. The path which seems to us most worth further exploration is that which leads away from mass statistics and toward the intensive study of the individual patient and his meteorological environment. Our study of 26 asthmatic children is only the first small step in this direction, but one which we hope to follow by others.

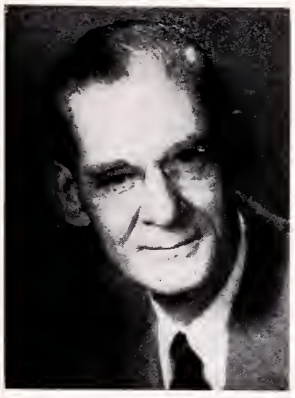
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# DEEP MYCOSES IN HAWAII

## Histoplasmin, Coccidioidin, Haplosporangin and Blastomycin Sensitivity and a Review of Cases of Mycoses

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HILO

THIS paper reports an effort to determine the prevalence of infection with Histoplasma capsulatum, Coccidioides immitis, Haplosporangium parvum and Blastomyces dermatitidis in Hawaii, by means of intradermal tests with the antigens of these fungi, and also to report the proven cases of the major mycoses that have occurred in this area.



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Fungus diseases resemble tuberculosis more closely than other non-tuberculous infections. Aspergillosis and moniliasis are usually quite mild conditions but histoplasmosis, coccidioidomycosis, blastomycosis, actinomycosis and cryptococcosis have a higher mortality rate than tuberculosis. The organisms causing these mycoses grow rather slowly in the tissues, induce the formation of giant cells and often cause hypersensitiveness of tissue similar to that caused by the tubercle bacillus.[1]

Many cases of fungus infections have been observed in Hawaii during the past 20 years, according to the records of the Bureau of Health Statistics of the Board of Health, of physicians, of civilian hospitals and of military hospitals. In 1934, Trexler mentioned Aspergillus, Mucor and Penicillium as causing otomycosis.[2] Crawford states that 60 per cent of infections of the external ear, that he has seen, were caused by fungi.[3] Arnold and Johnson have a record of treatment of at least 125 cases of moniliasis of the nails, skin and oral cavity during a four year period.[4] Bowles has discovered 240 cases of moniliasis of the vagina during the past year.[5] The following cases of the major mycoses have been reported or observed: histoplasmosis, 1; coccidioidomycosis, 1; actinomycosis bovis, 20; nocardiosis, 6; maduromycosis, 6; sporotrichosis, 10; and cryptococcosis, 4. Six cases of coccidioidomycosis were discovered here that apparently came from endemic regions. Four cases of blastomycosis have been diagnosed clinically but have not been proved by cultures or biopsies. Haplomycosis has not been reported. (This name was suggested by Emmons for a pulmonary disease of animals caused by the fungus Haplosporangium parvum.)[6] Willers of the Board of Agriculture and Forestry and Gooch of the Department of Health state that they observe actinomycosis in cattle frequently.[7]

There has been an increasing interest in sensitivity studies of the major mycoses since the beginning of the extensive research program of the United States Public Health Service in histoplasmosis in the Mississippi and Ohio River Basins and other areas,[8] in the study of coccidioidomycosis in the southwestern United States during the recent war by Smith of the University of California School of Public Health,[9] and others,[10] and in the study of practically all of the major mycoses by Conant and associates at the Duke University School of Medicine.[11]

Marks, Chief of the Territorial Bureau of Tuberculosis, states that he has observed many cases of pulmonary calcification which came from midwestern states, with negative tuberculin reactions but positive histoplasmin tests.[12] Peyton, and the attending staff at the Children's Hospital, Honolulu, have given over 400 histoplasmin tests during the past four years,[13] and Tompkins has given over 200 coccidioidin tests at the Kula (Tuberculosis) Sanatorium, Maui, with negative results.[14]

The above facts invited further investigation with the intradermal test, using the four available antigens. The skin test has proved to be of great value in the chain of diagnostic procedures during recent years.

### Material and Methods

The number of patients and employees, of each sex, and of lifetime and nonlifetime residents, who received sensitivity tests at Leahi (Tuberculosis) Hospital, Honolulu, at Puumaile (Tuberculosis) Hospital, Hilo, County of Hawaii, and at Laupahoehoe Sugar Plantation, County of Hawaii, since October, 1947, are shown in Table 1. Tests were given to 1,766 residents; 933 were lifetime residents and 833 were nonlifetime residents. Patients or employees who received tests at Leahi Hospital but who were born on other islands and came to Oahu as adults, and nonlifetime residents who were born on the United States mainland or in a foreign country, came to the Territory 6 to 60 years ago, as adults. The age groups are shown in Table 2. The number from each island who received tests is shown in Table 4. The number from each foreign country and the mainland is shown in Table 5.

The histoplasmin and coccidioidin skin tests were

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given to all of the 1,766 persons but the haplosporangin and blastomycin skin tests were given only to the last 499 persons of this group. Of this latter group, 225 patients and 31 employees were lifetime residents, and 224 patients and 19 employees were nonlifetime residents.

Undiluted histoplasmin (H-40), haplosporangin (HaI), and blastomycin (B-7) were provided by Dr. Arden Howell, Jr., United States Public Health Service, and undiluted coccidioidin was obtained from Dr. Charles E. Smith, of the University of California School of Medicine. The antigen dilutions were made in the Leahi Hospital Laboratory under the direction of Mr. James Shinn, Chief of the Laboratory. The antigens were diluted as follows: histoplasmin, 1:1,000; coccidioidin, 1:100; haplosporangin, 1:250; and blastomycin, 1:1,000. The technic of the standard intracutaneous tuberculin test was observed.

All tests were given by the writer and read by him except the 50 tests given to patients at the Puumaile Hospital, Hilo, which were read by Dr. William F. Leslie, Superintendent and Medical Director, and the 50 tests given to employees at Laupahoehoe Plantation, Hawaii, which were read by Dr. Leabert Fernandez, the Plantation Surgeon.

## Results

Table 2 records the number of positive reactors according to age groups, among the total of 1,766 residents, to histoplasmin (48 or 2.7 per cent) and coccidioidin (10 or 0.57 per cent), and the positive reactors among 499 of the 1,766 residents to haplosporangin (6 or 1.2 per cent) and to blastomycin (19 or 3.8 per cent). The greatest percentage of reactors was in the age groups 21 to 50.

Table 3 shows a total of 72 positive reactors to 1 or more antigens among the 1,766 residents; 64 reacted to only 1 of the 4 antigens and 8 reacted to more than 1 antigen, but no one reacted to all 4 antigens. Of the 72 reactors, 24 were lifetime residents and 48 were nonlifetime residents.

Table 4 shows the number of positive reactors to histoplasmin and coccidioidin among 933 lifetime residents, and also the number of reactors among 256 of these 933 residents to haplosporangin and blastomycin, according to the island of their birth. The percentage of positive reactors in the Territory is observed to be: histoplasmin, 15 or 1.6 per cent; coccidioidin, 2 or 0.2 per cent; haplosporangin, 2 or 0.7 per cent; and blastomycin, 10 or 3.9 per cent. Of the 15 who were positive reactors to histoplasmin, 3 were positive reactors to other antigens and only 6 (0.6 per cent of 933) had not traveled in endemic areas. The homes of 5 of this group of 6 were on the northeastern coast of the Island of Hawaii and the home of the sixth was in Wailuku, Maui. Only 2 (0.2 per cent of 933) were positive reactors to coccidioidin but they had traveled in endemic areas. One was a reactor to other antigens. The homes of these 2 persons were on the northeastern coast of Hawaii. Two (0.7 per cent of 256) were positive reactors to haplosporangin. One (0.39 per cent) of these reactors had always lived on the northeast coast of Hawaii; the other lived on Oahu, but he had traveled in endemic areas. Ten (3.9 per cent) of the group of 256 were positive reactors to blastomycin; three of these reactors lived on Hawaii, 5 were from Oahu, and 2 came from Maui. Eight (3.1 per cent) of this group had never left the Territory.

Therefore, of those who had never left the Territory, 6 (0.6 per cent) were positive reactors to histoplasmin, there were no reactors to coccidioidin, 1 (0.39 per cent) reacted positively to haplosporangin and 8 (3.1 per cent) were positive to blastomycin. (Table 3.)

Table 5 gives the number who reacted positively to histoplasmin and coccidioidin among 833 nonlifetime residents and also the positive reactors to haplosporangin or blastomycin among 243 of this group of 833, according to area of origin. A total of 33 (3.96 per cent of 833) reacted to histoplasmin; 8 (0.96 per cent of 833) were positive to coccidioidin; 4 (1.6 per cent of 243) reacted to haplosporangin, and 9 (3.7 per cent of 243) were positive to blastomycin.

Of the Japanese from Honshu, Japan, 2 were positive to histoplasmin, 1 was positive to haplosporangin, and 4 were positive to blastomycin; none was positive to coccidioidin; there were no positive reactors to any antigen among the 35 from Okinawa. Eleven Filipinos from North Luzon, P.I., were histoplasmin positive; 2 Filipino patients were positive to coccidioidin; one of these was from Manila and the other was from the Visayan Islands, P.I.; both had lived in the southwestern U.S. for twenty-two years and thirteen years respectively. The latter patient was also haplosporangin-positive; he had lived in Arizona for five years. Four from North Luzon reacted positively to blastomycin; one of these was also positive to histoplasmin. All of the positive reactors from the U.S. mainland were from, or had traveled in, endemic areas. One of the nurses had a severe reaction to histoplasmin here, but had had a mild reaction when tested by the United States Public Health Service, in a San Francisco Nursing School in 1945.

## Review of Cases of the Major Mycoses Occurring in the Territory

A brief description of 52 cases of the major mycoses that were imported into or contracted in the Territory during the past few years is presented in Table 6.

### *Histoplasmosis*

One case of histoplasmosis has been reported by Lam and Price[15] as occurring in a 45 year old Portuguese male who had never left the "Islands." The patient entered the hospital September 1, 1946. "He complained of 'tightness' in his jaw, first noticed the night before during a baseball game. This condition gradually became worse until he was hospitalized. . . ." "The patient was followed each day under the impression that he was an acute psychoneurotic. He would be all right, lying in bed with his mouth open, when looked at from behind a screen but if anyone entered the room, he would immediately clamp his jaws together. His condition gradually became worse and on the fifth hospital day, the temperature began to rise slowly until the seventh day, when it was 105° F., and when he died suddenly with pulmonary edema." An autopsy was performed.

The authors state that "This patient had some generalized systemic infection, producing pseudotubercles in the liver, peribronchial lymph nodes, lungs and spleen, with epithelioid cell formation, fibrosis, granulation tissue, and giant cell formation . . . these findings, however, were not typical of tuberculosis. . . ." "Examina-

tion of the recut specimens showed spherules in the giant cells, containing a small central dot. These averaged about 2 to 3 micra in diameter, and corresponded to the organisms found in histoplasmosis. Re-examination of all slides showed these minute bodies in the giant cells of the lung, and particularly the peribronchial lymph nodes, as well as independent of giant cells in the liver, adrenal, and in the blood clot from the heart. It seems the diagnosis of histoplasmosis is histologically justified on the above findings."[15]

### *Coccidioidomycosis*

The first of 6 cases of coccidioidomycosis imported into the Territory was mentioned by Ragle in 1934[16] and reported by Fennel in 1935[17] as having come to Oahu from the San Joaquin Valley, California. He entered Leahi Hospital March 24, 1933 as suspected tuberculosis, and expired March 28, 1933. The autopsy revealed many Coccidioides immitis.

The second case of coccidioidomycosis discovered here, which was also reported by Fennel,[18] occurred in a 65 year old Hawaiian stevedore in Hilo; he had never been away from the Territory. The onset was in October, 1934. When he presented himself at the office of Dr. Archie Orenstein, in Hilo, February, 1935, there was an ulcer of the right ankle. He was admitted to the Hilo Memorial Hospital February 16, 1935. Biopsy, cultures and guinea pig autopsy were positive for Coccidioides immitis by March 27, 1935, and an additional culture made from the purulent material from the right testicle of this guinea pig was also positive for Coccidioides immitis. The patient refused surgery unitl May 25, 1935, when the right leg was amputated above the knee. He was discharged from the hospital September 10, 1935 with the stump completely healed and with no evidence of dissemination.[19] According to the record of the Territorial Board of Health, this patient expired May 10, 1938, of "Cerebral Hemorrhage, Arteriosclerosis, Hypertension, Left Hemiplegia, Tertiary Syphilis, Previous Amputation of right leg for Coccidioides immitis."[20]

Four other proved imported cases of coccidioidomycosis have been treated on Oahu. The first of these four was a Japanese POW who expired here in a military hospital with disseminated disease, April 21, 1946.[21] The second case had a right upper lobectomy at Tripler Army Hospital, June 1, 1949. Sputum, guinea pig autopsy and sections of the lung were positive for Coccidioides immitis. The patient made a complete recovery.[23] The third case had gone on a hunting trip in San Joaquin Valley, California, February, 1950. He entered Tripler Army Hospital April 1, 1950, acutely ill, with lesions of the skin of the face, mediastinal glands and feet and with symptoms of central nervous system involvement. He was transferred to the "Zone of the Interior, May, 1950," with the diagnosis, "Disseminated coccidioidomycosis involving the mediastinal lymph nodes, skin of the face, bones of the feet, and probably of the central nervous system."[24] The fourth case was that of a male Filipino field laborer, 48 years of age, who entered a hospital in the San Joaquin Valley, California, about August 7, 1950 and was discharged September 12, 1950 with a diagnosis of "Pulmonary coccidioidomycosis, primary lesion." The chest x-ray revealed a "Pneumonitis, Left Lower Lobe," and the coccidioidin skin test was positive. This patient returned to Honolulu September, 1950 and obtained employment. A routine x-ray, April 30, 1951, revealed a lesion in the left lower lung field. A pneumonectomy was performed May 8, 1951. The pathologist reported that a mass 6 x 3 x 3 cm. from the apex of the lower lobe, left lung, revealed many Coccidioides immitis upon microscopic examination. A coccidioidin skin test was negative June 11, 1951, with a dilution of 1:100.[25]

Benson states that one of his patients, a housewife, 43 years of age, reports that she was admitted to a hospital in Tucson, Arizona, November 18, 1947, with an acute upper respiratory infection. An x-ray revealed a flocculent shadow in the right lower lung field, the coccidioidin skin test and the complement fixation test were positive, and erythema nodosum was present. The patient was discharged from the hospital December 19, 1947 with a diagnosis of pulmonary coccidioidomycosis, primary. The patient came to Honolulu in late December, 1947, and has shown no evidence of recurrence or dissemination.[27]

### *Actinomycosis*

In addition to the 11 cases of actinomycosis bovis (including 1 case of maduromycosis), reported by Gotshalk and Wilen in 1940,[28] 10 other cases have been discovered; five of these were of the cervical type, 1 of whom expired with meningitis, and the other 4 made a complete recovery; 5, 2 of whom expired, were of the pleuropulmonary form; and 1 was of the abdominal type. This last case was that of a Filipino housewife, 46 years of age, who had an appendectomy in October, 1948, followed by recurrent abdominal and intestinal abscesses, sinuses and fistulae formation with surgical intervention on 4 occasions; the patient expired February 5, 1950; the autopsy revealed actinomycotic abscesses of the liver. Nine of these 10 cases were males and 1 was a female; 1 was a Japanese farmer (who had cervical involvement followed by meningitis), 2 were Hawaiians and 1 was a male Caucasian school teacher who expired following a pneumonectomy. The ages were 23 to 71 years. Four gave a history of having had tooth extractions. Including the 10 cases of Gotshalk and Wilen (excluding the case of maduromycosis), there were 5 of the cervicofacial type (1 expired), 10 of the pleuropulmonary type (7 expired), 3 of the abdominal type (2 expired), 1 case with rectal abscess, and 1 case of involvement of the skin, a total of 20 cases. There were 14 cases from Oahu, 2 from Maui and 4 from Hawaii.[29]

### *Nocardiosis*

Six cases of nocardiosis have been observed. Four were pleuropulmonary in type; one of this group recovered following a right upper lobectomy, May 17, 1950; 1 recovered following a right pneumonectomy May 19, 1948 and a fistulectomy, July 31, 1948; 2 of this group expired. Of the 4 cases, 1 was a Hawaiian, 2 were Filipinos and 1 was a Caucasian.[35] There was one case of the abdominal type. This patient was a Caucasian marine, 42 years of age. The onset of his illness was January, 1947; later, a liver abscess and generalized peritonitis occurred. He expired May 3, 1947. The final diagnosis following autopsy was: "1. Abscess, liver, aerobic actinomyces (Nocardia); 2. Generalized peritonitis. . . ." The sixth case was that of a Japanese waitress, 28 years of age, who was observed to have mental symptoms, December, 1946. She was admitted to the Territorial Hospital March, 1947. A diagnosis of meningitis was made May, 1947. The spinal fluid was positive for the gram positive, acid-fast Nocardia asteroides by the Territorial Board of Health Laboratory

and by Dr. C. W. Emmons of the United States Public Health Service. The patient was considered clinically well June, 1947.[39]

### *Maduromycosis*

There were 4 cases of maduromycosis observed in field workers, including the patient of Gotshalk and Wilen, mentioned above. The 3 new cases were caused by the organism, Madurella mycetoma, found in 2 biopsies in 2 cases and in purulent material from a sinus in the third case.[40]

### *Sporotrichosis*

Ten cases of sporotrichosis were discovered that had been diagnosed by the finding of the organism Sporotrichum Schenckii in biopsies or cultures. Lesions were observed on the right upper extremity in 3 cases; left upper extremity in 3 cases; right lower extremity in 3 cases and left lower extremity in 1 case. Six of the patients were Filipinos (5 male and 1 female); 1 was a Japanese female; 1 was a Chinese-Caucasian female; 1 was a Caucasian male and 1 was a Caucasian female. The ages were 4 to 48 years. One of these cases, a Caucasian male, 14 years of age, on Maui, received a thorn injury in the right foot in 1938, followed by apparent complete recovery in about six weeks. In 1942, he became very ill with a pulmonary infection; the findings on his chest x-ray resembled the lesions of miliary tuberculosis. All laboratory tests were negative, but the pulmonary lesions disappeared with prolonged treatment with the iodides. The patient has been well and employed the past ten years.[42]

### *Cryptococcosis*

Four cases of cryptococcosis (torulosis) have been observed, here. The first case was that of a Caucasian housewife, 50 years of age, on Maui, who began having symptoms of involvement of the central nervous system in 1943. She became progressively worse and expired January 19, 1948. The autopsy revealed Cryptococcus neoformans.[44] The second case was that of a Hawaiian man 34 years of age, from Lanai. He had a diagnosis of Hansen's disease in 1943 and of pulmonary tuberculosis in 1944. The right ear began discharging purulent material in early 1947. Symptoms of involvement of the central nervous system occurred in September, 1947. The patient expired September 24, 1947. The autopsy revealed "Torula Meningitis."[45] The third case was that of a Chinese-Hawaiian child, 5½ years of age, who became ill with an acute upper respiratory infection and an acutely "inflamed ear," December 28, 1946. He was admitted to a hospital with symptoms of central nervous system involvement, January 4, 1947. The spinal fluid was positive for Cryptococcus neoformans on culture and guinea pig autopsy. The patient expired February 1, 1947. The autopsy revealed "Torula Meningitis."[46] The fourth is that of a male Hawaiian mechanic, 23 years of age, who became ill with symptoms of involvement of the central nervous system, July, 1949, while employed on Guam. He returned to Oahu for treatment. His spinal fluid has been positive for Cryptococcus neoformans by culture on several occasions. He received treatment to about March, 1952, but he has failed to appear for further treatment since that time.[47]

## Discussion

The findings in this study suggest that the deep mycoses are important in the differential diagnosis of obscure infections in the Territory of Hawaii, since many cases of deep fungus infection have their origin here, and any mycosis may be imported.

Since there is no evidence of endemicity of histoplasmosis, coccidioidomycosis, haplomycosis or blastomycosis in the Hawaiian Islands, according to the results obtained in this study, other reasons for the positive reactions to the antigens of these mycoses must be sought.

In June, 1951, Tucker[48] reported the results of intradermal tests made on 1,000 patients at the Colon Hospital, Panama Canal Zone. The antigens used produced positive reactions as follows: histoplasmin, 387 (38.7 per cent); coccidioidin, 8 (0.8 per cent); blastomycin, 38 (15.8 per cent of 241); candidin, 176 (88.4 per cent of 199) and tuberculin, 613 (61.3 per cent). Candidin was the only antigen that produced positive reactions in newborn infants, who presumably were not infected. Tucker mentions another study in which he tested 154 patients with coccidioidin, obtaining only one positive reactor. Concerning this former group and the group of 1,000, Tucker remarks, "As with the earlier series, no evidence of cross reactions with tuberculin was found; 61 patients in the combined series had bacteriologically proved tuberculosis and none reacted to coccidioidin. This is in accord with the studies of Kessel and by Aronson and his co-workers." Tucker also states that the "C. immitis has not been encountered here (Panama) clinically or at autopsy, and the mycologic division of the Board of Health Laboratory has not isolated the fungus." Although 38 or 15.8 per cent of 241 persons reacted to blastomycin, "Blastomycosis, superficial or systemic, has not been recognized in this area . . ." according to Tucker. In another report, November, 1952,[49] this same author states that in 1906, within 10 months, histoplasmosis caused 3 human deaths in the Panama Canal Zone, but since then, a period of forty-five years, there have been about 800,000 patients admitted to the Colon and Gorgas Hospitals, and about 18,600 postmortem examinations have been performed, without finding another human case. But considering the findings in these studies, as described above, "and the similar findings of other workers throughout the Americas where histoplasmosis has been found in recent years, the sum of the circumstantial evidence would support the contention that histoplasmosis does occur on the Isthmus of Panama, ap-

parently in the 'benign,' subclinical form." As an "addendum" to this paper, Tucker adds, "Two days after submitting this paper the writer was called to the laboratory to examine a lymph node smear made at the time of autopsy on a four-month old Panamanian, a native of Chilibre, R. de P. Morphologically typical tissue-phase Histoplasma capsulatum were seen . . ." "This case, the first in 45 years, supports nicely the prediction made in the text that additional cases might well be found in the future."

A report was made by Goddard, Edwards and Palmer,[50] in 1949, of tests performed on 16,320 student nurses in 11 representative cities throughout the United States. There were 19.5 per cent who were positive to histoplasmin. Sensitivity to this antigen varied from about 60 per cent in Kansas City, Mo., and Columbus, Ohio, to 10 per cent or less in Minneapolis, Denver and San Francisco. Histoplasmin sensitivity was observed to be greatest among residents of the eastern central states.

Tests on 6,000 students at the University of Chicago, from all parts of the United States and foreign countries, were reported in 1949 by Beadenkopf and others.[51] Of 5,528 persons who were born in the United States, 21.4 per cent were positive histoplasmin reactors, 4.3 per cent were positive to coccidioidin and 23.6 per cent were tuberculin positive. There were 472 foreign students who received tests with the following results: *Europe,* 164 persons; histoplasmin positive, 5.5 per cent; coccidioidin, 2.4 per cent and tuberculin, 56.1 per cent; *Canada and Alaska,* 110 students; positive to histoplasmin, 7.3 per cent, coccidioidin, 3.6 per cent, and tuberculin, 33.6 per cent; *China,* 67 students; histoplasmin positive, 1.8 per cent, coccidioidin, none, and tuberculin, 96.6 per cent; *Asia except China,* 33 students; histoplasmin reactors, 3.0 per cent, coccidioidin, none, and tuberculin, 51.5 per cent; *Other foreign areas,* histoplasmin positive, 13.9 per cent, coccidioidin, 0.9 per cent, and tuberculin, 54.6 per cent.

Prior and Allen[52] conclude from their tests at the Ohio State University that "There are more reactors to histoplasmin among males than among females," there are ". . . More reactors . . . found among lifetime residents of farms than among students without such residence," and that "Fewer reactors to tuberculin were found among lifetime residents of farms than among students without such residence."

In a study of histoplasmin and tuberculin sensitivity among Filipino medical and nursing students at the University of the Philippines, Bocobo and Reyes report[53] that 22 (4.61 per cent) of 477 tested were positive to histoplasmin and 467 (97.9 per cent) of 477 were positive to tuberculin. Two of these students came from the Visayas, three came from Manila, and the others came from practically all the major regions of Luzon. These authors mention a study by Malo and Belmonte in which they "failed to elicit any positive reaction to histoplasmin among 50 school children admitted into the pediatric ward of Santo Tomas University Free Clinic in Manila . . ." "Text books and articles on histoplasmosis list the Philippines as one of the endemic areas of the disease mainly on the strength of the original case report of Strong . . ." and that "There has been no other report . . . since . . ." according to Bocobo and Reyes.

Sexton, Ewan and Payne[54] tested 356 natives of the Pribilof Islands in the Bering Sea with histoplasmin, coccidioidin and tuberculin. There was only 1 (0.3 per cent) positive reaction to histoplasmin; this reactor was a native woman, 31 years of age, who had never left the "Islands." No native reacted to coccidioidin. There were 94 (26.4 per cent) natives who reacted positively to tuberculin. The authors state that there have been no cases of histoplasmosis or coccidioidomycosis reported from these Islands.

Only one case of histoplasmosis has been reported from the Territory, in a person who had never been away from the islands. The infection could have been imported, because Histoplasma capsulatum has been isolated from many animals and from the soil, and according to Reimann, three men acquired the disease from handling the soil from a silo in Indiana.[55]

The one case of coccidioidomycosis mentioned above, that occurred in Hilo, Hawaii, in 1935, apparently acquired the infection through an injury to the right foot while working on the Hilo wharves. Fennel[18] quotes Orenstein[56] as stating that ". . . Many of these (vegetables) come from the San Joaquin Valley and usually arrive in Hawaii with so much soil that they must be hosed off before being sold . . ." Fennel remarks that "Even a sophomore can make the diagnosis of an obscure disease if it be epidemic; this little diagnostic triumph of Dr. Orenstein and Miss Campbell[57] is a credit to Hawaii."

Concerning this case, Dr. C. E. Smith[9] of the University of California School of Medicine, wrote, May 11, 1948, ". . . We always suspected that either the history was inaccurate or he acquired the infection in some bizarre way such as contact with clothing or dusty products from an endemic area. Certainly, your findings show that coccidioidomycosis is not endemic in Hawaii." In another letter, dated September 13, 1950, Dr.

Smith remarks, ". . . The fact that no native Hawaiians have been reactors to coccidioidin is certainly in line with our experiences and with the reports that we have received from others who have made similar studies. With respect to your inquiry, we know of no reactors anywhere from the Pacific, including Australia, New Zealand, Japan, or from India either."

Forbus[58] mentions a case of coccidioidomycosis that occurred in Kansas who was infected by working with the meat of condemned cattle that had been used in making chicken feed. The primary lesion occurred on the finger.

According to Forbus,[59] coccidioidomycosis ". . . has now occurred in approximately 6,000 members of the armed forces in clinically recognizable form and probably in a far greater number as subclinical infection. These patients have been scattered literally throughout the world . . ." ". . . It is evident from our studies that disseminated coccidioidomycosis will continue to occur among those who have served in the armed forces for perhaps as long as ten years . . ."

Actinomycosis and nocardiosis (streptothricosis) occur all over the world.[60]

Sporotrichosis has been found in all continents. All studies indicate that the fungus is acquired by contact with plants.[61]

Cryptococcosis (torulosis) has been reported from Europe, South America, the eastern and southern United States, Hawaii, Australia, Japan, the Philippines, and some of the Islands in the Dutch East Indies.[62] Regarding the case mentioned in this paper, who apparently became infected in 1943 and lived to 1948, Tilden[45] remarks that ". . . this case is noteworthy because it represents an example of the disease progressing to the chronic stage, the duration of symptoms probably extending over a period of four years." Beeson[63] describes a case of nearly sixteen years' duration during which time the ". . . patient was relatively well, being able to do secretarial work, marry, and bear two children."

## Summary

In this study 1,766 residents of the Territory of Hawaii were given intradermal tests with histoplasmin and coccidioidin and 499 of this group were tested with haplosporangin and blastomycin. (See Tables.) There were 933 lifetime residents who received tests with histoplasmin and coccidioidin, and 256 of this group received tests with haplosporangin and blastomycin. Deducting the positive reactors who had traveled in endemic areas, the following numbers remain: histoplasmin, 6 (0.6 per cent of 933); (one of these 6 was also positive to blastomycin); coccidioidin, none; haplosporangin, 1 (0.4 per cent of 256); and blastomycin, 8 (3.1 per cent of 256); (one of these 8 was also positive to histoplasmin as noted above). Seven of these 14 positive reactors were from the northeast coast of the Island of Hawaii, 4 lived on Oahu and 3 came from Maui. (Table 3.)

Table 5 shows the results of tests on nonlifetime residents. It should be noted that the 2 positive reactors to coccidioidin from the P.I. lived in the southwest United States for several years.

There was no apparent evidence of cross reactions between the 4 antigens used in this study and tuberculosis. There were more positive reactors among males than among females. The greatest sensitivity was between the ages of 21 and 50 years. There were more positive reactors in rural districts than in urban communities. The case of histoplasmosis and the case of coccidioidomycosis were probably caused by imported organisms. There were 6 cases of imported coccidioidomycosis that presented diagnostic problems.

Considering the above facts and the small number of positive reactors to histoplasmin, haplosporangin and blastomycin, the absence of coccidioidin sensitivity, and the fact that no proved cases of haplomycosis or blastomycosis have been diagnosed here, it must be assumed that the positive reactions were due either to cross reactions between the antigens used in this study and antigenically related fungi, or to the existence of benign forms of the mycoses. But it is evident that the sources of the following fungus diseases are present in the Territory: actinomycosis bovis, nocardiosis, maduromycosis, sporotrichosis, cryptococcosis and moniliasis. There are also many other fungi which may present diagnostic problems.

## Acknowledgments

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Puumaile Hospital

# SIXTH INTERNATIONAL CONGRESS OF LEPROLOGY

## Hawaii Delegate's Report

HARRY L. ARNOLD, JR., M.D.
HONOLULU

THE Sixth International Congress of Leprology, under the sponsorship of the Spanish Government and the International Leprosy Association, was held in Madrid, Spain, October 3 to 11, 1953. It was attended by approximately 350 physicians and other leprosy workers from almost every country in the world, only a few of whom were officially designated as representatives of their respective governments, but all of whom were registered as *miembros efectivos* and allowed to participate actively in discussions and in the final decisions.



DR. ARNOLD

General officers of the Congress were: President, Dr. José A. Palanca (Spain); Vice-President, Dr. H. W. Wade (U.S.A.); Secretary, Dr. Ernest Muir (England); and Vice-Secretary, Dr. Felix Contreras (Spain). A General Council of 25 members and an Executive Committee of 7 completed the Congress' organization.

The Congress divided itself into four parts: presentation of technical papers; deliberation of committees; the usual invaluable informal discussions outside of the regular working hours; and special events, both educational and social, such as tours to Toledo, Trillo Leprosarium, Fontilles Leprosarium, Chapineria Preventorium, and elsewhere; scientific movies; receptions; and a final banquet.

### Highlights

The Congress offered few surprises, and in several areas merely reaffirmed decisions made by the Fifth Congress at Havana in 1848. Two outstanding developments were brought out, however:

Vaccination of leprosy contacts (*convivientes*) against leprosy by the induction of a positive lepromin reaction through the use of B.C.G. vaccine was recommended for "intensive trials" and "wider investigation" by the Committee on Immunology, and was stated by the Committee on Epidemiology and Prophylaxis to be one of "the bases of a modern antileprosy campaign." The Council recommended deletion of the latter statement, regarding it as somewhat premature and overenthusiastic; but in the final Plenary Session, it was specifically approved along with the rest of the report. This will be discussed in detail below.

The other outstanding development was a further report by V. R. Khanolkar of Bombay on the application of his tissue concentration method of finding leprosy bacilli, which reveals them in several unexpected situations, e.g. (1) in all active cases of leprosy, in both lesions and normal appearing skin, even when these are bacteriologically negative by standard methods of examination; (2) in the normal skin of long inactive, clinically recovered, bacteriologically negative cases of leprosy; and (3) in the normal-looking skin of contacts who have not (yet) developed any clinical evidence of the infection! Rolla Wolcott, of Carville, told me he had been able to confirm Khanolkar's findings on numerous occasions.

### Technical Papers

No adequate summary can be made of these at this time, because (1) many of those scheduled were not read, often because their author was not present when called upon; (2) other commitments, chiefly to committee sessions, prevented my full-time attendance at the scientific sessions; and (3) the simultaneous translation, though usually helpful and sometimes excellent, was often unable to keep pace with an author hurrying to "tell all" within his ten allotted minutes.

Because of this, and because the committee reports convey the most important information about the Congress, only brief resumés of a more or less random selection from the technical papers are presented herewith. The full text of all papers read will appear in the Transactions of the Congress early next year.

Nelson de Souza Campos (Sao Paulo, Brazil) reported the results of oral B.C.G. vaccination of 1,658 leprosy contacts, using 200 mg. orally once a week for three doses. A year later, 10 cases of leprosy were found in this group, and all were

tuberculoid. In roughly double the number of unvaccinated contacts, over the same period of time, 179 cases of leprosy were found—48 tuberculoid, 47 lepromatous, and 84 indeterminate.

Convit, Gonzalez, et al., reported on the results of B.C.G. vaccination in 1950 (by injection) of 106 out of 107 persons, all of whom were living in more or less direct contact with cases of lepromatous leprosy. In March, 1953, all but 1 of the 106 were found to be Mitsuda positive; the unvaccinated control had lepromatous leprosy; and 3 of the vaccinated (all Mitsuda positive) persons had incipient tuberculoid leprosy.

Wade (Philippines) reported observation of the suppression of the reaction to both living and heat-killed lepromin in sensitized dogs by both parenterally injected cortisone and locally injected hydrocortisone. He concluded that the reaction is an allergic phenomenon. Fernandez (Argentina) reported confirmatory observations in 12 cases of leprosy.

Möller Christensen, Melsom and Waaler (Norway) expanded their previous reports of observations, in both 13th to 16th century skulls and a dozen or so present-day cases, of atrophy of the anterior nasal spine resulting from leprosy.

Eleanor Alexander-Jackson (New York) expanded her previous report of a pleomorphic, often motile, Corynebacterium-like organism cultured repeatedly from the blood of 20 leprous patients and inoculated readily into mice, for which it is pathogenic (alopecia, skin ulcers, brain lesions). She believes it is M. leprae. No additional skin-test results were reported—a serious omission, as Wade pointed out in the discussion. The general tenor of the reception of this paper was decidedly skeptical.

Floch (France) reported for his associate, Sister Marie Suzanne, on a mycobacterium isolated from an untreated lepromatous case. It was neither claimed, nor believed by most of the discussants, that this was Mycobacterium leprae; but many felt it to be a new organism, and Wade described studies done by himself indicating that it was antigenically distinct from both M. leprae and the Stefansky bacillus of rat leprosy.

Molesworth (Malaya) described a severe form of tuberculoid leprosy commonly encountered among Chinese and Malay patients in his institution. Most of the discussants felt that he was describing the "borderline" type of cases (*v.i.*, under Classification Committee Report).

Lavalle Aguilar (Mexico) described the first human case of Mycobacterium ulcerans infection observed in the Western Hemisphere. Cultures were positive at 32° C. after two months, and the lesion, a destructive ulceration of the hand resulting in loss of the index finger, healed under diamino diphenyl sulfone (DDS) treatment in about eight months.

Khanolkar (Bombay) and Cochrane (London) postulated a natural history of leprosy consisting of an initial lepromin-negative, bacteriologically positive (by concentration methods) phase; then a lepromin-positive, clinically indeterminate phase; and finally a clinically determinate phase either lepromin-positive ("lepride," or tuberculoid), lepromin-negative ("leproma"), or lepromin doubtful-or-negative ("dimorphous," corresponding to the "indeterminate" form if macular, or the "borderline" form if infiltrated). The description of individual patients as they observed them passing through one or several of these phases was decidedly impressive. The demonstration of numerous acid-fast bacilli in skin biopsies from contacts several months in advance of the appearance of clinical demonstrable leprosy in them was even more impressive.

Contreras, Guillén and others (Spain) reported that 50 to 150 cc. of whole blood, either intravenously or intramuscularly, had a beneficial effect on patients undergoing lepra reactions.

Doull (U.S.), Davison (South Africa) and Guinto (U.S.) reported on the first series of clinical evaluation studies sponsored by the Leonard Wood Memorial Foundation at four leprosaria (Aisei-en and Komyo-en, Japan; Eversley Childs, Philippines; and Westfort, South Africa). Nearly 1,000 patients, divided into a control group and five treatment groups, treated with Diasone, DDS, and dihydrostreptomycin sulfate alone and in combination with Diasone and with paraaminosalicylic acid, were observed at sixteen-week intervals for forty-eight weeks by a consultant unaware of what was being done for them. A total of 862 patients completed the schedule of treatment and examinations. This thorough and carefully organized study led to two principal conclusions: (1) none of the five methods of treatment gave superior results, either clinically or bacteriologically, to any of the others, though all five did much better than the control group at all institutions; and (2) even in the control group, a substantial proportion of cases showed clinical and bacteriological improvement.

TB1 (Tibione) as an antileprosy drug received support from at least three workers: Vegas, Gomez Orbaneja, and Laviron. They gave 3-400 mg. orally daily, 200 mg. orally daily, and 600 mg. intramuscularly weekly, respectively, as a

maximum dose, and all were enthusiastic about the effectiveness of the program and its freedom from side reactions.

N. P. Buü-Hoi, of the Radium Institute (Paris), reported that diamino diphenyl sulfoxide is only about one-fifth as toxic for mice as diamino diphenyl sulfone, and that it is readily available as an intermediate in the manufacture of the latter.

Nuñez Magro, Such, and Garcia Perez, of Trillo Leprosarium (Spain), reported enthusiastically on the use of orthopedic surgery in the rehabilitation of persons crippled by leprous neuritis. Little could be done for the foot except arthrodesis, and occasional tendon transplants for equinovarus deformities. For the hand, however, tendon transplants in accordance with principles laid down by Sterling Bunnell had given most gratifying results.

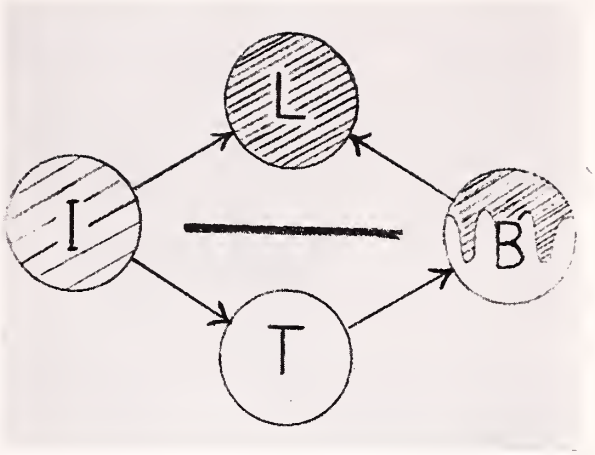



FIG. 1. Diagrammatic scheme of the Madrid Classification, slightly modified from Latapi. Arrows indicate the transitions from group to type, or type to group, that are most likely to occur. The horizontal bar indicates the improbability of transition directly from either polar type to the other.

## Committee Reports

The reports of the five technical committees (Classification, Treatment, Immunology, Epidemiology and Prophylaxis, and Social Assistance) were all accepted by the Congress at its final plenary session, subject to final editorial emendations. Their text is available upon request, and will be published in 1954; only a few highlights from them are given herewith. I was invited to attend three sessions of the Classification Committee, and was one of the two United States members of the Social Assistance Committee.

**Classification.** The basically binary classification of Hansen, with the terminology approved at Havana in 1948, was adopted, with clinical varieties. The lepromatous (L) type was divided into macular, diffuse, infiltrated, nodular, and (questionably) pure neuritic varieties, no symbols being assigned these varieties. The tuberculoid (T) type was divided into macular ($T_m$), minor tuberculoid ($T_T$), major tuberculoid ($T_t$), and pure neuritic ($T_n$) varieties. The indeterminate (I) group (*not* a "type", be it noted) was divided into a macular ($I_m$) and a pure neuritic $I_n$) variety. And the borderline (Wade) or dimorphous (Khanolkar and Cochrane) group (again, not a "type") was set up with its own symbol (B). The relationship among these is clearly indicated by the following chart presented by Drs. Rodriguez and Latapi, of Mexico. The definitions (q.v.), following in general those of the Havana Congress, but somewhat more concise, are as follows:

**Lepromatous type** (L). A malign type, especially stable [as to type, not as to severity], strongly positive on bacteriological examination, presenting more or less infiltrated skin lesions, and negative to lepromin. The peripheral nerve trunks become manifestly involved as the disease progresses, habitually in symmetrical fashion and often with neural sequelae in advanced stages.

**Tuberculoid type** (T). Usually benign, markedly stable; generally negative on bacteriological examination; presenting in most cases erythematous skin lesions which are elevated marginally or more extensively; positive to lepromin. Sequelae of peripheral nerve trunk involvement may develop in a certain proportion of cases, and this may give rise to serious and disabling deformity. This frequently appears to occur as a result of extension from or through cutaneous nerve branches, rather than of systemic dissemination, and consequently it is often asymmetric and unilateral. Tuberculoid leprosy should be subdivided as follows:

*Macular tuberculoid* ($T_m$). These cases present macules with clear-cut and definite margins, the surface generally smooth and dry, invariably with some loss of cutaneous sensibility; almost always negative, or with at most only a few bacilli, on bacteriological examination.

*Minor tuberculoid* (micropapuloid) ($T_t$). Skin lesions are only slightly to moderately elevated, often only at the margin or even a part of the margin, usually with irregularity of the surface. The condition tends to be relatively superficial, and palpable enlargement of cutaneous nerves associated with the lesions is infrequent.

*Major tuberculoid* (plaques, annular lesions, etc.) ($T_T$). Skin lesions are often smooth of surface, but more markedly elevated and thickened than in the minor variety, the affected zone usually broader; the more recent lesions may show only partial central recession or no recession; because of the degree of the condition in the deeper levels of the skin, manifest extension in the associated cutaneous nerves is relatively frequent and marked.

**Indeterminate group** (I). A benign form, relatively unstable, seldom bacteriologically positive,

presenting flat skin lesions which may be hypopigmented or erythematous; the reaction is lepromin negative or positive. Neuritic manifestations, more or less extensive, may develop in some cases which have persisted as of this group for long periods. The indeterminate group consists essentially of the "simple macular" cases. These cases may evolve toward the lepromatous type or the tuberculoid type, or may remain unchanged indefinitely.

Borderline (dimorphous) group (B). A malign form, very unstable, almost always strongly positive on bacteriological examination, with the lepromin reaction generally negative. This group may arise from the tuberculoid type as a result of repeated reactions, and sometimes evolves to the lepromatous type. The nasal mucosa is generally bacteriologically negative. The skin lesions are usually seen as plaques, bands, nodules, etc., with a regional distribution similar to that of lepromatous leprosy, except for conspicuous asymmetry. The ear lobes are likely to present the appearance of lepromatous infiltration. The lesions frequently have a soft or succulent appearance and their periphery slopes away from the center and does not present the clear-cut, well-defined margins seen in the tuberculoid type; the lesions are therefore liable to be mistaken for lepromas. The surface of the lesions is generally smooth, with a shiny appearance and a violaceous hue, sometimes (in light skins) with a brownish (sepia) background.

Reactional phases. All forms of leprosy may go through phases of reactivation or reaction. We would particularly draw attention to three main reactional phases of leprosy, as follows:

*Reactional lepromatous leprosy.* Two forms must be distinguished:

(1) Lepra reaction (of which there may be two or more varieties) consists essentially of the aggravation of pre-existing skin lesions, usually with fever.

(2) Erythema nodosum leprosum is characterized by fever and the appearance of erythematous nodular skin lesions, and has as a rule a favorable prognosis.

We would further draw attention to the special feature known as Lucio's phenomenon or erythema necrotisans, occurring only in diffuse lepromatous leprosy and more particularly in Mexico and Central America.

*Reactional tuberculoid leprosy.* Infiltrated lesions of active, succulent appearance, without central retrogression, develop abruptly from major tuberculoid lesions or from lesions of lesser degree (minor tuberculoid or even indeterminate), or on sites not previously involved. In some cases, more or less numerous and widely scattered, metastatic small nodules may appear. The lesions of the peripheral trunk nerves may become marked, and necrosis, and even abscess formation, may occur. On bacteriological examination, while the cutaneous lesions are positive, sometimes strongly so, the nasal mucosa frequently remains negative. During the reaction, the response to lepromin may decrease in intensity. Fever and constitutional symptoms do not ordinarily occur.

*Reactional borderline (dimorphous) leprosy.* In reactional borderline cases, the lesions show extreme edema, erythema and desquamation; the reaction frequently extends to nerves; and marked nerve pain and dysfunction develop. The skin lesions may during this phase ulcerate superficially, or sometimes widely and deeply; and the skin is acutely tender. Bacteriologically the lesions are strongly positive. The lepromin reaction is usually negative.

Wade insisted, in a dissenting opinion, on the necessity of creating a separate "maculoanesthetic" category for all the nonlepromatous macular cases (of probable tuberculoid structure) not showing clinically elevated skin lesions—elevation being, to his mind, an essential criterion for inclusion within the tuberculoid type. His point is that until such elevation occurs, the tuberculoid pattern is not firmly enough established to justify attributing to these flat macular ($T_m$) cases the same degree of resistance that is characteristic of the $T_t$ and $T_T$ cases.

**Treatment.** DDS (4,4′ diamino diphenyl sulfone) was stated to be safe, as effective as, and less expensive than, the numerous substituted sulfones. A dosage range between 300 and 1200 mg. weekly was approved, administration being daily, on alternate days, twice weekly, or weekly, and either orally or intramuscularly. Gradual induction of treatment was emphasized, the initial dose being not over one-fourth the standard, and six to eight weeks' time was advised for the increase to the standard level, even in robust patients. Late results of treatment were said to vary so widely in different centers that no general conclusions could be drawn at the present time.

The likelihood of reactivation in "arrested" cases was emphasized, and maintenance treatment was recommended wherever it was practicable, for no specified or limited period of time.

**Immunology.** The desirability of a standardized, centrally prepared lepromin was again mentioned, and again for practical work the Mitsuda-Hayashi antigen (Wade's modification) was approved. The reading of the Fernandez and Mitsuda reactions was redefined as follows:

**The Early Reaction.**

This is a red, infiltrated lesion, sometimes noticeable in twelve hours after the injection, the size and evolution of which resemble those of the tuberculin type. It reaches its maximum in twenty-four to forty-eight hours, and begins to diminish after seventy-two hours. In strongly positive cases, it persists for a longer time in the form of a dark halo surrounding the nodule which forms later.

For the purpose of reading the reaction the only element of importance is the infiltration. Reactions which only show erythema should be considered doubtful or negative, as should also reactions which appear very early and regress or disappear within forty-eight hours. A clear, amoeboid margin indicates a particularly strong positive.

It is recommended that the reading of results after forty-eight hours should conform to the following criteria:

Negative (—) Absence of reaction or erythema without infiltration, or erythema with infiltration of a diameter less than 5 mm.

Doubtful (±) Erythema and infiltration with a diameter more than 5 mm. and less than 10 mm.

Positive (+) Erythema and infiltration with a diameter of more than 10 mm. and less than 15 mm.

Positive (++) Erythema and infiltration with a diameter more than 15 mm. and less than 20 mm.

Positive (+++) Erythema and infiltration of more than 20 mm.

Delayed Reaction.

This is constituted by a nodular infiltration which begins from the first week after the injection, reaches its maximum about the fourth week, and then regresses, generally leaving atrophy or a scar. Sometimes the evolution is accelerated and reaches its peak before the third week, while at other times, it is delayed in reaching its peak until the fourth week. In negative or doubtful cases it may be well to make a reading after the sixtieth day. Intensely strong positives may result in ulceration. The criterion of reading should be based not only on the size of the infiltration, but also on its appearance and evolution.

Negative (—) Absence of all local reaction between the first and second weeks.

Doubtful (±) Slight infiltration, barely detectable, and less than 3 mm. at the point of inoculation.

Weak positive (+) Frank infiltration of between 3 and 5 mm. diameter at the point of inoculation.

Frankly positive (++) Nodular infiltration of more than 5 mm. diameter.

Strongly positive (+++) When the infiltration results in ulceration.

Lepromin conversion produced by B.C.G. vaccination was recognized as a fact; whether it carries with it any such degree of immunity to the disease as is associated with a naturally positive lepromin reaction was said to be unknown as yet. Intensive trials of oral B.C.G. vaccination, which was stated to be free from risk, were recommended to clarify this point.

**Epidemiology and Prophylaxis.** Outstanding in this report was the inclusion, among the fundamentals of an adequate antileprosy program, B.C.G. vaccination of (lepromin-negative) contacts of leprosy cases. Preventive chemotherapy was recommended for all contacts over 10 years of age failing to get a positive lepromin reaction from the B.C.G.

**Social Assistance.** This committee, of which I was one of the two United States members, reaffirmed the decision of the Havana Congress to recommend avoidance of the word "leper" or its equivalent in other languages, but to continue to use the word "leprosy" as the scientific designation for the disease.

They also, among other things, urged that gainful occupations be encouraged by all methods for both isolated patients and ex-patients, and that non-contagious patients have their lives and normal occupations interfered with as little as possible. The isolation of severe, deformed, advanced cases of leprosy in separate institutions, in order to avoid the depressing effect of association with such patients upon milder, earlier, less advanced cases, was recommended by the committee.

## International Leprosy Association

The day following the final plenary session of the Congress, the International Leprosy Association held its quinquennial meeting. Among other items of business, Dr. H. W. Wade (Culion) was re-elected President and Dr. John Lowe (London) was elected Secretary-Treasurer to replace Dr. Ernest Muir, who had announced his intention to retire.

India had renewed its invitation, declined in 1948, to hold the next Congress in Calcutta, and Japan also offered an invitation for 1958. The invitation to Calcutta was accepted, and the hope expressed that the Japanese Government might see fit to repeat its invitation for the 1963 Congress.

1020 Kapiolani St.



# *The President's Page*

As we turn the clock backward from this era of atom bombs and wonder drugs to the middle of the 19th century, we find ourselves in a quiet peaceful seaport town called Honolulu, in the Kingdom of Hawaii . . . and the year is 1856. There is no hustle and bustle as we know it in this small town. The streets are not paved, and most of them are irregular lanes only wide enough for the horse and buggy. The buildings are small frame structures and the value of real estate in downtown Honolulu has not reached astronomical figures. The town at night is illuminated by the tropical moon and there are no neon lights of brilliant colors. We find that the Hawaiians outnumber the other ethnic groups in Hawaii's population, and they are hardy, husky, and strong. They smile and laugh and bubble over with the Spirit of Aloha. Most of the newcomers to Hawaii came from the coastal areas of New England around Cape Horn to settle in this Paradise of the Pacific. Among the newcomers to Hawaii are missionaries, farmers, whalers, tradesmen, adventurers and a few doctors of medicine. Our doctor is a kindly, understanding gentleman who makes his rounds on foot or horseback up dusty Fort Street or even all the way up the narrow Nuuanu trail. He shares the intimate secrets of his many patients and knows their various organic ailments.

It was in this memorable year of 1856 that the handful of doctors of medicine founded the Hawaii Medical Society which through the century has become the Hawaii Medical Association. In 1956 we will celebrate our 100th anniversary, and it seems fitting and proper that a Centennial Committee begin now to plan for that celebration and to review medical progress in Hawaii from 1856 to 1956. Do you know the history of the physicians who formed our Association in 1856? Do you know any anecdotes of the time? Do you have any historical records of interest concerning medicine in Hawaii? Our Centennial Committee will appreciate your help.

Aloha,

R. K. Thungstoon, M.D.

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# [EDITORIALS]

## BUREAU OF MEDICAL ECONOMICS, LTD.

A long step toward an effective and potentially self-supporting public relations program was taken by the Honolulu County Medical Society when they incorporated, last October, the Bureau of Medical Economics. The Bureau is headed by a full-time Executive Secretary, Mr. Richard M. Kennedy.

The idea of this organization has been under consideration for several years, ever since some of the society's members became aware of the successful establishment and operation of such enterprises in certain mainland medical societies, notably the Alameda-Contra Costa Society in Oakland, California. Information on the latter organization was brought back three years ago by Dr. Homer Izumi to the Honolulu Society's Public Relations Committee, but the time was not quite ripe for action.

Further planning during the past year by the joint Public Service Committee of the territorial and county organizations under the chairmanship of Dr. Colin McCorriston, supported by the agreement of a substantial proportion of the Honolulu County Society's members to loan the new corporation $50 each to finance its inception, culminated last fall in the formal organization of the new Bureau.

The Bureau's efforts are being concentrated initially on becoming self-supporting through the operation of a medical credit bureau, serving the members of the Honolulu County Medical Society. When this is running smoothly, it is anticipated that the Bureau will, as stated in its Articles of Incorporation,

> own, operate, maintain and conduct an accounting service, a bookkeeping service, a billing service, a credit exchange service, a telephone exchange service for doctors of medicine, doctors of dentistry or other persons, organizations, associations, corporations or firms providing medical care and treatment for the ill and the injured, and to provide such other services for such persons, organizations, associations, corporations or firms as may be of use and benefit to them.

The Bureau will also assume the responsibility for recommending reduced fees, or free care, for patients unable to pay the usual rates.

Mr. Kennedy, the Bureau's Executive Secretary, has also been designated Executive Secretary of the Honolulu County Medical Society. It is expected that much of his time in the latter capacity, once the Bureau's operations have become more or less routine, will be devoted to furthering the Society's public relations program.

The officers of the corporation are the officers of the Honolulu County Medical Society, and its members are the members of the same organization. Its operations are entirely on a non-profit basis: all profits, beyond those needed to maintain reasonable reserves, are to be returned on a pro rata basis to those doctors for whom it has made collections during the fiscal year.

The establishment of the Bureau of Medical Economics means that Honolulu is maintaining its position among the active and progressive medical societies of the nation. It is a tribute to the active leadership of President William Ito and the other officers, and Chairman McCorriston and the other members of his committee, Drs. Sylvia Haven, Robert Katsuki, Louis Gaspar, Homer Izumi, and David Pang. It is a challenge to the members of the Honolulu County Medical Society to see that it receives the backing and support that so worthwhile an enterprise deserves.

## PEPTIC ULCER: AN OBSOLETE TERM

Semantics—bad semantics—can be lethal! The expression "peptic ulcer" has been fatal to some patients, and can be fatal to more if it is not abandoned.

There was a time when duodenal ulcers and stomach ulcers seemed to have enough in common to justify an expression which would include them both. "Peptic ulcer" served that purpose well enough in its day, but its day is past.

The expression "peptic ulcer" means "benign ulcerating lesion of the stomach or duodenum"—caused, according to Dorland's *American Illustrated Medical Dictionary*, by gastric juice. This is all right for the duodenum. It is *not* all right—as a clinical or roentgenographic diagnosis — for the stomach. There it always includes an uncertain proportion, varying from 10 to 20 per cent according to the criteria used for diagnosis, of cases of ulcerating gastric carcinoma which cannot be identified as such until a surgical specimen is examined microscopically.

"Peptic ulcer" is therefore far too inclusive a term to be useful; it is, indeed, a dangerous term, since it seems to say more than it does. "What is good treatment for peptic ulcer?" is as foolish a question as "What is good treatment for a skin ulcer?" Yet it is asked, and debated, as if it were meaningful; and many a case of early and potentially curable gastric cancer goes on to an inoperable or incurable stage because his doctor is thinking in terms of "peptic ulcer."

Semantics — the meaning of words — is the business of editors; and it should be the business of editors to scotch this dangerous and obsolete expression wherever they encounter it. "Peptic ulcer" should be taboo in medical publications. Its elimination might save some lives.

## OASI—COMPULSORY CHARITY!

Old Age and Survivors Insurance—the OASI—is out-and-out compulsory charity for the older generations at the expense of the younger. It is only pretending to be insurance. Currently, an estimated 6 to 20% of the benefits being paid out were actually prepaid by the beneficiaries or their employers. A 62-year-old beneficiary brought under the scheme in 1951 could have purchased $23,000 worth of retirement income for $121.50—and the difference would have been just plain charity, contributed involuntarily by persons in all income brackets! It is robbing the young to pay the old.

The extension of this morally indefensible plan to self-employed persons has been opposed openly by the American Bar Association, the American Dental Association, the American Farm Bureau Federation, and the American Medical Association.* Up to now, OASI has not covered members of groups represented by these organizations, as well as accountants, architects, optometrists, professional engineers, veterinarians, and others — also excluded, in most if not all instances, by their own request. Notwithstanding this fact, social security consultants have recommended to President Eisenhower—and he has in turn recommended to Congress — that members of these groups be included under the act in the future.

Doctor, don't fail to read the article on this topic in the November 7 J.A.M.A., by Blasingame and Dickinson. Whether you're in favor of a steal like this, or opposed to it, you need the information there. Even if you wouldn't mind accepting a few thousand dollars worth of charity from your descendants, you'll find that the average doctor has to wait an extra 10 years to collect it. The whole program is badly in need of revision, and Blasingame and Dickinson offer specific suggestions for this. A compulsory pension will inevitably lead to a compulsory national health service. Find that November 7 J.A.M.A., and inform yourself—it's later than you think!

## LEPROSY BACILLI BY CONCENTRATION TECHNIQUE

Khanolkar's surprising demonstration[1] that M. leprae can be found by a concentration method in "bacteriologically negative" cases of leprosy, long-burned-out cases, and even in clinically nonleprous contacts, referred to elsewhere in this issue[2], is of enormous theoretic importance, but little immediate practical significance. Its impact on leprologists has been minimized by its inconspicuous initial publication, so that even today, well over a year after its appearance, the only published comment on it known to us is one made by Cochrane[3] exactly two years ago, when it was still in press.

In regard to diagnosis, it may be supposed that acid-fast bacilli morphologically indistinguishable from M. leprae, and found in tissues—by whatever means—may reasonably be supposed to *be* M. leprae, and therefore may be assigned the same

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* See the recent action of the A.M.A. House of Delegates, reported on page 212 of this issue.—Ed.

[1] Khanolkar, V. R., and Rajalakshmi, K.: A Method of Concentrating M. leprae from the Tissues, Leprosy in India 24:47, 1952, abstracted in Leprosy Briefs 4:10 (Oct.) 1953.

[2] Arnold, H. L., Jr.: The Sixth International Congress of Leprology, Hawaii Med. J. 13:195 (Jan.-Feb.) 1954.

[3] Cochrane, R. G.: The Influence of Recent Advances in Leprosy on Present-day Conceptions of the Disease in Relation to Diagnosis, Treatment and Prevention. Edinburgh Med. J. 19:509 (Nov.) 1952.

diagnostic significance as if they had been found by the usual methods of examination.

The finding of bacilli by such methods when they are lacking by standard methods of search should not be taken to mean, however, that the case is actually an open, potentially contagious one, Cochrane believes. We emphatically endorse this view. Standards for determining the contagiousness or non-contagiousness of patients with leprosy are based upon the present standard methods of searching for bacilli, and are as sound as our experience tells us they are in relation to those methods of search. We have always suspected that, in the majority of bacteriologically negative cases, more intensive search would probably reveal a bacillus or two. Khanolkar has merely confirmed this suspicion.

There need be no immediate revision of our present standards for determining the need and duration of isolation of "open" cases of leprosy in endemic areas. They may be bacteriologically crude, but so far as we know they are still epidemiologically sound.

## POSTGRADUATE EDUCATION DEDUCTIBLE!

Expenses incident to postgraduate education for lawyers—and physicians—are now allowable deductions under the federal income tax laws as ordinary and necessary business expenses. So said the U.S. Court of Appeals, Second Circuit, last April 14, in a unanimous decision which was not (and cannot now be) appealed by the government.

Whether such deductions will be allowed on Hawaii Territorial income tax returns is not yet known; it is to be supposed that the physician who has his wits about him will take them, and wait to see whether they are allowed or not.

The ruling applies, it should be noted, only to postgraduate education aimed at keeping a physician up-to-date in his own field. Thus, special studies for the purpose of making a general practitioner into a radiologist, or an otolaryngologist, or the like, would probably not be allowed as deductions.

## BY-PRODUCTS OF FRIGIDITY

A Scottish general practitioner, writing in *Lancet*[1] has recently made some intriguing observations on frigidity, in an article from which the following paragraphs are borrowed:

> The assertion that love, while playing but a part in the life of man, is woman's whole existence, is one of those misleading half-truths; for, whereas the erotic requirements of the female are intermittent and transitory, the male is enslaved by his need of female affection throughout his span of life. On finding in marriage the futile pretence, passivity, or protest in lieu of subtle caress and passionate embrace, he is by no means unhurt; but the emotions engendered by this threat to his security are of a very different nature from those of his frigid wife.
>
> The husbands of the greater part of this series of 296 married women were still alive during the investigation, and a number were known to me. Unfortunately, my attention was not drawn to them until 1944 when many of them had drifted beyond my reach. The data obtained from just over two-fifths of them indicate their more typical reactions. Roughly, 25% of them became addicted to alcohol and 20% contracted peptic ulcer, while an unknown but substantial proportion found solace in the arms of other women. Many compensated through vocational diligence in gaining positions of influence and responsibility in the community.

Who says the National Health Service has stultified the British GP?

[1] Robertson, H. G., Lancet, Jan. 10, 1953.

# THIS IS WHAT'S NEW!

Wimberley and Kern review **penicillin** reactions and note 16 anaphylactic **deaths** in an eighteen months' period. (*Am. J. Med. Sci.* 226:357 [Oct.] 1953.)

They also summarize minor reactions such as hives which may persist as long as fifteen months. If your patient is the apprehensive type, he can be cautioned that his greatest anxiety should be confined to the first 15 minutes after the administration, as almost all of the anaphylactic deaths occurred during this period. The late reactions are usually benign except for sporadic fatalities associated with exfoliative dermatitis, purpura and perhaps systemic lupus and periarteritis nodosa.

Fortunately all penicillin reactions can be prevented if the physician takes the following precautions:

1. Routine history for familial and personal allergy—especially in regard to penicillin.
2. Scratch test patients with positive allergic histories or previous use of penicillin.
3. If scratch test is negative, perform an intracutaneous test and read in 20 min., 24 hrs. and 48 hrs.
4. Be ready to apply a tourniquet above the site of injection (choose appropriate site) and make cruciate incision with suction—same as with snake bite if anaphylactic reaction begins to appear.
5. Have syringes loaded with epinephrine and a parenteral antihistaminic. Also have an oxygen tank in the immediate vicinity.
6. Have patient sign form releasing physician from all responsibility. Patient by this time can be observed crouching on far corner of examining table.
7. Give any drug except penicillin.

* * *

**Angina pectoris,** in spite of "great advances" in its management in the last few years, still yields best to **nitroglycerine.** Pentaerythitol tetranitrate **(Peritrate)** may be of some value in reducing frequency of attacks. (Uricchio and Calenda, *N. Eng. J. Med.* 249:689 [Oct. 22] 1953.)

* * *

**Primary atypical pneumonia responds no better to aureomycin than to placebos.** Two hundred and twelve patients with atypical pneumonia were evaluated and half treated with aureomycin (0.5 gm every 6 hr.) and half treated with placebos. In this epidemic there was no significant difference in response to the two forms of treatment. (Walker, *Am. J. Med.* 15:593 [Nov.] 1953.)

* * *

**Total intake of calories** with resultant increase in weight appears to be more important than total fat intake as far as **blood fat** is concerned. In general, increase in weight resulted in increase in Sf 12-20 lipoprotein and cholesterol while decrease in weight through dieting resulted in corresponding decrease in these substances. If cholesterol and certain lipoproteins have anything to do with atherosclerosis, it's a wise woman and a wiser man who keeps his weight down. (Walker, *Ann. Int. Med.* 39:705 [Oct.] 1953.)

* * *

Twenty-three patients with penicillin-sensitive **bacterial endocarditis** were cured after only two weeks of treatment. Therapy consisted of 1 million units of aqueous **procaine penicillin** and 1 gm. of **dihydrostreptomycin** intramuscularly every twelve hours. Twenty cases of streptococcus mitis, 2 cases of salivarius, and one unidentified streptococcus were involved. Cutting the treatment time from six down to two weeks would appear to be cutting it a bit thin but was successful here. (Geraci and Martin, *Circulation* 7:494 [Oct.] 1953.)

* * *

**Hyaline membrane** in the lung of newborns, a cause of atelectasis, might be due to aspiration of **amniotic fluid**. Claireaux, a morbid anatomist in London, has reproduced similar lesions in rats by appropriately treated amniotic fluid injected into the trachea. He believes the squamous cells are of some importance in the production of this condition. (Lancet 2: 749 [Oct. 10] 1953).

FRED I. GILBERT, JR., M.D.

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## Recent Acquisitions

**Anatomy and Physiology**

California, U. of. *Publications in physiology*, v. 9 No. 1, c1953. (gift of U. of Cal.)
Friedman, S. M. *Visual anatomy: thorax and abdomen*. c1953. (gift of publ.)

**Arthritis**

Lewin, Philip. *Arthritis and the rheumatic diseases*. c1951. (gift of publ.)
Talbott, J. H. *Gout and gouty arthritis*. c1953. (gift of publ.)

**Biochemistry**

Luck, J. M., ed. *Annual review of biochemistry*. v. 22. 1953.

**Cancer**

Clemmesen, J. *Symposium on geographical pathology and demography of cancer*. 1905.
Iason, A. H. *Gastric cancer*. c1953. (gift of publ.)
Kottmeier, H. L. *Carcinoma of the female genitalia*. c1953. (gift of publ.)

**Cardiovascular system**

Braunstein, J. R. *The ballistocardiogram*. c1953. (gift of publ.)
Green, H. D., ed. *Shock and circulatory homeostasis*. Trans. . . 2nd conf., Oct. 19-21, 1952. c1953. (gift of Josiah Macy, Jr. Foundation.)
Katz, Louis N. *Experimental atherosclerosis*. c1953. (gift of publ.)
Noble, F. W. *Electrical methods of blood-pressure recording*. c1953. (gift of publ.)
Starr, Isaac *Physiologic therapy for obstructive vascular disease*. c1953. (gift of publ.)
Zdansky, Erich. *Roentgen diagnosis of the heart and great vessels*. c1953. (gift of publ.)

**Dermatology**

Shelley, W. B. *Classics in clinical dermatology*. c1953. (gift of publ.)
Simons, R. D. J., Ph., ed. *Handbook of tropical dermatology*. c1952.
Stratton, E. K. *Atlas of regional dermatology*. c1953. (gift of publ.)

**Diagnosis**

Hyman, H. T. *Handbook of differential diagnosis*. c1953. (gift of publ.)
Jones, J. M., ed. *Physician's desk reference*. 7th ed. 1953. c1952. (gift of Medical Group)

**Dietetics**

Hawaii Dietetic Assn. *Hawaii diet manual*. Rev. ed. c1953. (gift of Hawaii Dietetic Assn.)
Pollack, Herbert. *Therapeutic nutrition*. 1952. (gift of Squibb)

**Drugs**

Engle, D. J. *Physiological and therapeutic effects of corticotropin (ACTH) and cortisone*. c1953. (gift of publ.)
Mote, J. R., ed. *Proceedings of the second clinical ACTH conference*. c1951.
Slesser, A. E. *The pharm-assist manual*. c1953. (gift of publ.)
Welch, Henry. *Antibiotic therapy*. c1951. (gift of publ.)

**Endocrinology**

Bradley, S. E., ed. *Renal function*. Trans. . . 4th conf., Oct. 22-24, 1952. c1953. (gift of Josiah Macy, Jr. Foundation)
Lewin, S. A. *Sex after forty*. c1952. (gift of publ.)
Ralli, E. P., ed. *Adrenal cortex*. Trans. . . 4th conf., Nov. 12-14, 1952. c1953. (gift of Josiah Macy, Jr. Foundation)
Ullery, J. C. *Stress incontinence in the female*. c1953. (gift of publ.)

**Neurology**

Goodman, J. I. *The diabetic neuropathies*. c1953. (gift of publ.)
Prather, G. C., ed. *Injuries of the spinal cord*. c1953. (gift of publ.)
Spurling, R. G. *Lesions of the lumbar intervertebral disc*. c1953. (gift of publ.)

**Nursing**

Gillan, R. I. *The head nurse looks at her job*. 1952. (from Nurses' Assn.)
Reinhardt, J. M. *Society and the nursing profession*. c1953. (from Nurses' Assn.)
Swanson, Marie. *School nursing in the community program*. c1953. (from Nurses' Assn.)

**Obstetrics**

Dieckmann, W. J. *The toxemias of pregnancy*. 2nd ed. c1952. (gift of publ.)

**Ophthalmology**

Tower, Paul. *Differential diagnosis of common diseases of the eyeground*. c1953. (gift of publ.)
Weinstein, Paul. *Glaucoma pathology and therapy*. c1953. (gift of publ.)

**Orthopedics**

Klein, Armin. *Slipped capital femoral epiphysis*. c1953. (gift of publ.)
Snapper, I. *Multiple myeloma*. c1953. (gift of publ.)
Snapper, I. *Rare manifestations of metabolic bone disease*. c1952. (gift of publ.)

**Pathology**

Anderson, W. A. D., ed. *Pathology*. 2nd ed. c1953. (gift of publ.)

**Pediatrics**

Holt, L. E. *Pediatrics.* 12th ed. c1953. (gift of publ.)

**Psychiatry**

Altschule, M. D. *Bodily physiology in mental and emotional disorders.* c1953. (gift of publ.)

Berglund, H. J. *It's not all in your mind.* c1953. (gift of publ.)

Nichtenhauser, Adolf. *Films in psychiatry, psychology and mental health.* c1953. (gift of publ.)

Oberndorf, C. P. *A history of psychoanalysis in America.* c1953. (gift of publ.)

Spiegel, E. A., ed. *Progress in neurology and psychiatry.* v.8. c1953. (gift of publ.)

Stephens, E. A. *Lawless youth.* c1953. (gift of publ.)

Thompson, G. N. *The psychopathic delinquent and criminal.* c1953. (gift of publ.)

Wortis, Joseph, ed. *Basic problems in psychiatry.* c1953. (gift of publ.)

**Respiratory system**

Galloway, T. C. *Treatment of respiratory emergencies, including bulbar poliomyelitis.* c1953. (gift of publ.)

Johnston, J. A. *Nutritional studies in adolescent girls and their relation to tuberculosis.* c1953. (gift of publ.)

Smul, J. S. *Respiratory diseases and allergy.* c1953. (gift of publ.)

**Surgery**

Gross, R. E. *The surgery of infancy and childhood.* c1953.

Horsley, G. W. *Operative surgery.* In 2 vol. 6th ed. c1953. (gift of publ.)

Thorek, Max. *A surgeon's world.* c1943. (gift of Dr. Robert Johnston)

**Therapeutics**

Johns, H. E. *The physics of radiation therapy.* c1953. (gift of publ.)

Saklad, Meyer. *Inhalation therapy and resuscitation.* c1953. (gift of publ.)

**Miscellaneous**

Jaeger, E. C. *A source book of medical terms.* c1953. (gift of publ.)

Millman, Milton. *Pardon my sneeze.* c1952. (gift of publ.)

Moss, E. S. *Atlas of medical mycology.* c1953.

*Quarterly cumulative index medicus.* v. 50. July-Dec., 1951. c1953.

Sears, T. P. *The physician in atomic defense.* c1953. (gift of publ.)

Smith, L. A. *Peptic ulcer.* c1953. (gift of publ.)

Von Foerster, Henry, ed. *Cybernetics.* Trans . . . 9th conf., March 20-21, 1952. c1953. (gift of Josiah Macy, Jr. Foundation)

Of all the many interests of the late Dr. "Pete" Halford, none was closer to his heart than the Endowment Fund of the Honolulu County Medical Library. In fact, much of the money that is now in that fund came as a direct result of his energetic efforts to pry it out of Honolulu's doctors and laymen. It thus seems particularly appropriate that the Doctors of the Medical Group have chosen a gift to this fund as their memorial to him. Mrs. Halford has also turned over to the Library, gifts received from his friends here and on the mainland. It has been decided by the Library Board to keep this money earmarked, so that if, in time, a new Library or addition is built, an alcove might be furnished and named for Dr. Halford, who did so much to insure the future of this institution.

## POST A.M.A. TOUR TO HAWAII

Plans are now being made for a tour to Hawaii following the annual A.M.A. meeting to be held in San Francisco next June. This tour will begin on June 26 and end July 3, 1954. Locally this post convention tour will be considered a semi-annual meeting of the Hawaii Medical Association.

Two interesting scientific sessions are being planned. The first will be held in the Mabel Smyth Auditorium on the morning of June 28. The second will be at the Royal Hawaiian Hotel on the afternoon of June 29. We hope to have 300-400 visiting doctors. This should give a good choice of mainland speakers. We are also planning local participation in the sessions with encouragement of audience discussion. The scientific program should be informative and worthwhile for every physician practicing in Hawaii.

The social activities being planned include a luau preceded by a cocktail party and considerable opportunity for visiting with our mainland guests.

We hope local physicians will plan to attend the scientific sessions as well as the social events of this meeting. The price for registration and social events will be reasonable. Local drug houses will probably sponsor the cocktail party.

WALTER B. QUISENBERRY, M.D.
*Chairman of Arrangements*

# BOOK REVIEWS

## Peptic Ulcer.

By Lucian A. Smith, A.B., M.D., M.S. in Medicine, F.A.C.P. and Andrew B. Rivers, M.A., M.D., M.S. in Medicine, F.A.C.P., 576 pp., illustrated, Price $12.50, Appleton-Century-Crofts, Inc., 1953.

All gastroenterologists and abdominal surgeons would benefit from the close study of the recent publication of Smith and Rivers on peptic ulcer. The chapter devoted to the history of gastric surgery is interesting. There is considerable space devoted to the anatomy of abdominal pain and the interpretation of this knowledge as related to lesions of the stomach and duodenum.

I strenuously disagree with the use of the term "peptic ulcer" as related to ulcerating lesions of the stomach; it intimates that the lesions are benign, whereas everyone should be cognizant of the fact that all such lesions should be considered malignant until proven otherwise by careful examination of the ulcer by a competent pathologist.

The statement is made, "We do not intend to convey the impression that it is impossible to differentiate benign and malignant ulcers of the stomach." It is almost always impossible to make this differentiation (when dealing with an ulcer that proves to be malignant) at a time when surgery offers any hope of cure or hope of long palliation. In speaking more specifically about the treatment of gastric ulcer, the following statements are made: "When the clinician must choose the treatment for a patient with gastric ulcer, he must admit that whereas the odds may favor benignancy of the lesion, all evidence prior to microscopic study is only of relative value." And again "the risk of medical treatment of an apparently benign gastric ulcer is approximately seven times as great as the risk of partial gastrectomy for such a lesion." Since the hope for surgery being of value in gastric malignancy depends upon its use in the incipient stage of the disease, and when one considers its safety and the good results obtained and the doubtful permanent results from medical treatment of gastric ulcers, and the serious complications that may arise, it would seem that the chapter on medical treatment might better be omitted. It seems to me there is no place for conservatism when the patient is a suitable surgical risk.

With these few fundamental differences in opinion regarding the approach to the problems of ulcerating lesions of the stomach, the volume is, in my opinion, of great merit.

J. E. Strode, M.D.

## Stress Incontinence in the Female.

By John C. Ullery, M.D., F.A.C.S., F.I.C.S., 149 pp., illustrated, Price $6.75, Grune & Stratton, Inc., 1953.

Over 20 years ago I attended lectures by the then young Dr. Ullery on the subject of stress incontinence. His life-long interest in this field and his increasing knowledge of the subject are summarized in this well-written monograph. As Dr. Charles Read of London states in the foreword, "This work represents the most authoritative and complete treatise on the subject in any language." All physicians studying or treating patients with stress incontinence will be well-advised to have this book at hand. The large type, the excellent paper, and the ample illustrations add to the excellence of the monograph.

H. McLeod Patterson, M.D.

## Treatment of Respiratory Emergencies Including Bulbar Poliomyelitis.

By Thomas C. Galloway, M.D., 94 pp., Price $3.00, Charles C. Thomas, 1953.

This is one of the monographs in the series of small, soft cover booklets of Charles Thomas, publishers, in the American Lecture Series. Although it is written by one author, the bibliography is complete and the information is in accord with other authorities on the subject.

The major message of this useful work concerns the role of tracheotomy and management of airway problems in bulbar poliomyelitis. However, the pathological physiology of disturbances in oxygenation is discussed in diseases in which mechanical, neurogenic, or secretory factors afford the airway obstruction. There are brief, practical notes on the indications and techniques for the use of oxygen, nasopharyngeal suction, postural drainage, and the new surface tension reducing drugs in aerosol.

The author includes a chapter dealing with the management of inadequate airway in diphtheria, botulism, tetanus, anesthetic and barbiturate overdose, cerebral trauma, tumor and vascular accidents, and in postoperative and degenerative conditions. The use of curare in tetanus is discussed.

This booklet offers interesting reading to all physicians and a practical reference and complete bibliography to those dealing with any aspect of its widely met subject matter.

John Frazer, M.D.

## The Diabetic Neuropathies.

By Joseph I. Goodman, M.D., Siegfried Baumoel, M.D., Leonard Frankel, M.D., Louis J. Marcus, M.D., and Sigmund Wassermann, M.D., 138 pp., illustrated, Price $4.75, Charles C. Thomas, 1953.

In this interesting little monograph the authors review the various theories as to the etiology of diabetic neuropathy, and conclude that it is probably due to poor control of the patient's diabetes. Successful treatment is dependent upon satisfactory management of the diabetic condition.

This neuropathy is characterized by nocturnal pain in the lower extremities, and is temporarily relieved by activity. The ankle jerk was almost invariably absent in these patients. A patchy hypohidrosis was also a manifestation of diabetic neuropathy. For those of you not familiar with this little-emphasized facet of diabetes this little book will be very enlightening.

Raymond deHay, M.D.

## Holt Pediatrics.

By L. Emmett Holt, Jr., M.D. and Rustin McIntosh, M.D., Twelfth Edition, 1485 pp., illustrated, Price $15.00, Appleton-Century-Crofts, Inc., 1953.

This standard pediatric textbook has grown considerably since its first edition in 1897, but is about the same size as it was 20 years ago. The emphasis on some subjects, however, has changed. For instance, there is now over twice as much space devoted to the premature infant as there was in the 11th edition of 1933.

The general arrangement and system of multiple authorship is the same as in the previous editions. Most of the contributors are from New York and Baltimore. The grouping of diseases according to anatomical location or systems facilitates quick reference to a specific subject and also to closely related ones.

Since most textbooks are two years or more behind the current literature at the time of publication, one should realize its limitations, particularly in the field of treatment. However, it is a fine textbook of diseases of infancy and childhood.

W. A. Myers, M.D.

## Gastric Cancer.

Alfred H. Iason, M.D., 316 pp., illustrated, Price $7.50, Grune & Stratton, Inc., 1953.

This monograph is full of facts and no doubt involved a considerable amount of work; however, the subject matter is not too well integrated, and there appears to be a lack of balance. For instance, there is a long chapter on anatomy and very little on physiology. It is unfortunate also that the author did not present his own views, which could have been of great interest due to his considerable experience. There is an excellent bibliography.

Samuel L. Yee, M.D.

## Lawless Youth.

By E. A. Stephens, M.D., 315 pp., Price $3.50, Pageant Press, 1953.

There could be extracted from Dr. Stephens' book: (1) a very usable set of rules for sincere parents; (2) a very lurid set of detailed sketches of youthful lawlessness on a relative par with the sensational exposures which appear from time to time in our popular illustrated periodicals; and (3) a collection of statistical data which may or may not reflect real and painstaking research in the areas explored by the author. Although the author's child guidance principles are set forth in very readable language, there is nothing particularly new about them, and it is questionable whether the sincere parent should be required to wade through shocking examples of sexual deviations and warped personalities to get at them. The statistical data are not going to be particularly valuable until the author gives us some better idea of the characteristics of the total number of individuals with whom he was dealing.

To probation and parole and institutional personnel this reader would suggest: Read the book and compare it with other contemporary writings on the subject. To doctors: Compare the excellent study by Lucien Bovet, M.D., prepared for the World Health Organization. To parents: Better stick to Dr. Spock.

Gerald R. Corbett*

* Judge, Juvenile Court, Honolulu.

## Nutritional Studies in Adolescent Girls and Their Relation to Tuberculosis.

By Joseph A. Johnston, M.D., 320 pp., illustrated, Price $7.50, Charles C. Thomas, 1953.

The author presents a twenty-year nutritional study on adolescent girls who had tuberculosis. With 184 charts and 194 illustrations, he attempts to show that the abrupt increase in the incidence of the adult form of tuberculosis in the adolescent group is related to a failure to meet nutritional requirements for growth. Furthermore, he attempts to show that the disease process can be favorably altered by promoting a normal nutritional state and by replenishing nutritional deficits.

This book should be of value to workers in the fields of nutrition and tuberculosis.

Clifford Kobayashi, M.D.

## Experimental Atherosclerosis.

By Louis N. Katz, M.A., M.D. and Jeremiah Stamler, A.B., M.D., 375 pp., illustrated, Price $10.50, Charles C. Thomas, 1953.

This monograph deals only with atherosclerosis as a distinct pathologic entity, not related to senescence, but caused by a metabolic disturbance, that may occur at any age.

The authors offer considerable experimental evidence that the problem is closely related to a derangement in the metabolism of lipid and lipoprotein molecules. However, the real solution to the problem will have to wait for a better understanding of lipid metabolism and factors which alter it.

This monograph contains 375 pages and a rich bibliography of experimental data.

Henry C. Gotshalk, M.D.

## Pardon My Sneeze.

By Milton Millman, M.D., 217 pp., Millman Books, 1952.

An excellent little book prepared for the layman who suffers from allergies of the upper respiratory tract. The title "Pardon My Sneeze" is catchy but does not do justice to the contents of the book. The volume is written in clear concise style with illustrative case histories throughout. In places one could almost think he were reading a short novel. The presentation for its purpose is excellent.

The book is divided into three sections. The first discusses the phenomena of the allergic mechanism, diagnosis, treatment required in allergic diseases, and several chapters on food allergy. The second section describes in plain language symptoms of the major allergies and what may be done to either prevent or control such symptoms. The third section deals with methods and means of eliminating and avoiding causative factors. There are excellent chapters on avoidance of dust and other air-borne allergens and on the proper method of keeping food diaries and allergic diaries, and several chapters on food elimination, diets with ample recipes and menus to provide the allergic individual sensitive to foods with a better means of living a normal and healthful life.

This book can be highly recommended as a guide to the individuals who suffer from allergic diseases.

Tell Nelson, M.D.

### Progress in Neurology and Psychiatry.

Edited by E. A. Spiegel, M.D., Volume VIII, 591 pp., Price $10.00, Grune & Stratton, Inc., 1953.

This book gives a survey of the most important published studies of the past year. I was impressed with the work reported in the fundamental sciences of the anatomy, physiology, pathology and pharmacology of the nervous system; with the work done in neurology, clinical and surgical; and with the chapters on electroencephalography and electromyography. The research reported in psychiatry, however, was relatively unimpressive. Convinced as I am that this is the most important field in medicine, I was disappointed in the relatively poor showing of original work in psychiatry; it may be that the lack of impressiveness in the psychiatric section reflects the orientation of the editors. The book is, however, a valuable effort to give the doctor a perspective on the research going on in his field, in a condensed form which can be assimilated and used as a basis for further study and reading.

J. Robert Jacobson, M.D.

### Handbook of Differential Diagnosis.

By Harold Thomas Hyman, M.D., 716 pp., Price $6.75, J. B. Lippincott Company, 1953.

This handbook is a systematized compilation of over 200 divisions of differential diagnosis, alphabetically arranged and briefly described by over 1500 signs and symptoms. These divisions are in general arranged to enumerate the possible causative mechanisms in the different disease entities including etiology and predominant system responses, and the differential diagnostic features together with pathognomonic or suggestive characteristics including signs, symptoms, therapeutic tests and laboratory findings.

It is not all inclusive and complete; however, it covers the more often encountered medical entities and attempts to assist the modern practitioner in approaching the problem of differential diagnosis from an all-inclusive point of view. Concisely written and extensive in its coverage, this handbook is intended merely as a complement to the heavier and more detailed medical textbooks and is certainly no substitute for a well-rounded medical library as well as experience. As a volume of small bulk, it has its value in daily clinical practice.

Edward Y. Yamada, M.D.

### Bodily Physiology in Mental and Emotional Disorder.

By Mark D. Altschule, M.D., 228 pp., Price $3.75, Grune & Stratton, Inc., 1953.

The author presents in detail some valuable concepts in regard to alterations in bodily functions during periods of stress. Dr. Altschule emphasizes what he considers to be limitations in present psychiatric approaches in regard to etiology of psychosomatic illness, absence of adequate psychological control in research, confusion in terminology, and incompleteness of symbolic formulations.

The author's observation of physiologic and biochemical fluctuation is excellent, and this book would be a valuable contribution to any medical library.

Ellsworth B. Harris, M.D.

### Lesions of the Lumbar Intervertebral Disc.

By R. Glen Spurling, M.D., 148 pp., illustrated, Price $4.75, Charles C. Thomas, 1953.

This monograph is similar in many ways to the author's earlier work with Keith Bradford which appeared in 1945. The present volume gives a good account of the history of the lesion, the embryological and anatomic considerations, and then goes on to describe the pathological process in the ruptured disc.

The clinical picture and diagnosis are explained on the basis of the above and then two chapters are devoted to therapy and end results. The author's easy style and the large clear print make for easy reading. One is impressed by the author's conservative, realistic approach in giving practically all patients a trial on conservative treatment. He feels that fusion is only rarely indicated.

John J. Lowrey, M.D.

### The Physics of Radiation Therapy.

By Harold Elford Johns, M.A., Ph.D., F.R.S.C., 286 pp., illustrated, Price $8.50, Charles C. Thomas, 1953.

This new book is the third of the projected American Lectures in Radiation Therapy series edited by Dr. Milton Freedman. The author's stated object is to supply students and physicians with the fundamental physical principles basic to an understanding of radiotherapy, and in this object he succeeds notably. Throughout the book, special emphasis has been placed on the fundamental and important concept of energy absorption in tissue. This volume is well organized throughout and contains numerous reference tables and formulae which should prove very helpful to radiologists and all others interested in the field of roentgen therapy, radium therapy and the use of radioactive isotopes.

Richard D. Moore, M.D.

### Pathology.

Edited by W. A. D. Anderson, M.A., M.D., F.A.C.P., Second Edition, 1393 pp., illustrated, Price $16.00, C. V. Mosby Company, 1953.

The first edition of Anderson's *Pathology,* which appeared in 1948, met with the universal approval of pathologists. Dr. Anderson with the aid of 31 contributors produced a textbook of pathology which included for the first time sections on such specialized fields as the organs of special sense, the skin, bones, joints and nervous system. This made the book particularly valuable as a reference work.

The second edition written by Dr. Anderson and 32 contributors has been condensed in some parts and revised in most, and contains numerous although relatively minor additions. The section on thyroid neoplasms, for example, has been rewritten to embrace modern concepts, and additions include a discussion of hormonal effects on neoplasms, and recently recognized diseases such as cat scratch fever. The new edition contains 1,241 illustrations compared to 1,183 in the first, and these are of good quality. The bibliography is even more extensive than in the first edition. The book has been printed on paper of good quality. As in the first edition, fine print is used for material of lesser importance, and the new double column style makes this material easier to read.

I. L. Tilden, M.D.

### Atlas of Distribution of Diseases.

Poliomyelitis; Cholera; Malaria; Helminthiasis; Dengue and Yellow Fever; Plague; Leprosy; Study in Human Starvation—Sources of Selected Foods; Study in Human Starvation—Diets and Deficiency Diseases; Rickettsial Diseases, Price $1.25 per copy, American Geographical Society, 1950-1953.

A beautiful set of world maps indicating the world distribution of various diseases and disease vectors. They would make excellent study material for schools teaching classes in social hygiene, bacteriology, etc. They contain an enormous amount of information attractively and well illustrated.

HARRY L. ARNOLD, JR., M.D.

### Sex After Forty.

By S. A. Lewin, M.D. and John Gilmore, Ph.D., 200 pp., Price $3.50, Medical Research Press, 1952.

This is an excellent handbook for the laity on problems which we either have, are or shall face in the intricate and often baffling experience which is called life. The authors have done an excellent job in the presentation of problems which arise after forty and their treatise deals equally with the counsel for both sexes.

The book may be said to be divided into three main phases; the first six chapters are devoted to anatomy and physiology of the sex organs. They are written in clear cut language which could be understood by any layman. There are illustrations which are simple to follow and aid in the presentation of the subject matter. The second portion is devoted to the relationship of the sexes during the turbulent years and is presented with excellent taste and decorum. Five chapters are devoted to this section. What might be termed the third portion with five chapters is given over to sound and fundamental advice on the problems in the light of their medical implications. There are excellent chapters on cancer, its detection and what to do about it, and also on emotional problems and how to master such episodes. The final chapter is one devoted to twenty actual case histories illustrating points brought out in the text. There is also a short concise glossary as a helpful guide and aid in understanding terminology.

This book can be recommended highly as a guide to people either entering into or already past the forty mark.

TELL NELSON, M.D.

## Also Received

### The Surgical Clinics of North America.

October, 1953, Nationwide Number-Ambulant Surgery, pp. 1229-1541, figs. 333-451, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1953.

### A History of Psychoanalysis in America.

By C. P. Oberndorf, M.D., 280 pp., Price $5.00, Grune & Stratton, Inc., 1953.

Interesting to psychiatrists and historians.

### A Source-Book of Medical Terms.

Text by Edmund C. Jaeger, D.Sc., foreword by Irvine H. Page, M.D., 145 pp., illustrated, Price $5.50, Charles C. Thomas, 1953.

"Here are found assembled in alphabetical sequence the numerous word elements, combining forms, prefixes and suffices from which modern medical terms have been coined."

### Films in Psychiatry, Psychology and Mental Health.

By Adolf Nichtenhauser, M.D., Marie L. Coleman and David S. Ruhe, M.D., 269 pp., Price $6.00, Health Education Council, 1953.

"The core of this book is a series of fifty-one penetrating, critical reviews of films in psychiatry, psychology, and mental health, supplemented by brief descriptions of fifty additional significant and available films in this area released for showing up to January 1953."

### Respiratory Diseases and Allergy.

By Josef S. Smul, M.D., 80 pp., Price $2.75, Medical Library Company, 1953.

". . . owing to the exclusion of many useless theories this small volume completely covers all diseases of the respiratory system."

### Electrical Methods of Blood-Pressure Recording.

By Frank W. Noble, M.E.E., 56 pp., Price $3.00, Charles C. Thomas, 1953.

A valuable but a highly technical book on "hydraulic and electric systems which have been used in manometers of the diaphragm type."

### Review of Physiological Chemistry.

By Harold A. Harper, Ph.D., Fourth Edition, 328 pp., Price $4.00, Lange Medical Publishers, 1953.

By a Professor of Biochemistry who is also a lecturer in Surgery. An eyeopener for a graduate of 15 years ago.

### Autopsy Diagnosis of Congenitally Malformed Hearts.

By Maurice Lev, M.D., 194 pp., illustrated, Price $7.50, Charles C. Thomas, 1953

Beautifully printed, profusely illustrated with 21 pages of references classified by specific regions. Cardiologists take notice.

### The Medical Clinics of North America.

November, 1953, Philadelphia Number—Clinical Medicine, pp. 1595-1917, figs. 206-236, $18 per clinic year, cloth binding, $15 per clinic year, paper binding, W. B. Saunders Company, 1953.

## WESTERN CONFERENCE OF PREPAID MEDICAL SERVICE PLANS

For the first time, Mr. Veltmann of H.M.S.A. and I attended the annual Western Conference of Prepaid Medical Service Plans, which met at the Fairmont Hotel in San Francisco November 5 and 6. It was most interesting to hear the representatives of the various prepaid plans from all the western states and western Canada present the problems and the accomplishments of their organizations. Throughout the meeting it was stressed that the problems of the prepaid plans are the problems of the doctors and that such plans cannot continue to exist and to improve without the wholehearted support of the medical profession. Much was also brought out about the growth and weaknesses of Permanente-type plans.

Of particular personal interest to me was a paper by Ralph W. Neill, president of the Medical Society Executive Secretaries Conference of the United States. Two obvious points on which the medical profession is being judged today, said Mr. Neill, are (1) The ten percent in the doctors' midst who are giving the ninety percent the bad publicity and causing all the troubles we now face; and (2) The prepaid programs, with which much of the public is far from satisfied. He directed our attention to the flood of medical articles in the national magazines, newspapers and labor publications, some of them factual to a degree, others sensational and erroneous, but many of them pointing out weaknesses in the present forms of medical care; to the demand of medical leaders with stature, that the profession be more definite in its attitude toward unethical members; and lastly, to the fact the profession, staggering around in considerable confusion under all these happenings, still is reluctant to face its issues fearlessly.

Mr. Neill urges that we reconstruct our thinking about prepaid plans, in order to convince the people, our customers, that we are sincere and mean business. Let's tell our plan managers to "get on the stick," said he, and produce programs that will give the public an article that agrees fully with all the nice things we've been saying about it—a product the public will be glad to buy, and one that we can proudly sell. I leave the "new look" I advocate to the doctors and their statistically-minded plan-managers, he continued. If you physicians will say the word, your managers will come up with the right figures. Then, let's carry on a continuous educational program for those doctors who are reluctant to see anything good in prepaid medicine.

Fee schedules are vexatious things, said Dr. Morris K. Crothers, vice-president of the Oregon Physicians' Service. They are vexatious to compile. They cannot possibly be entirely consistent and equitable; and frequently there are gross inequities. No two gastric resections for instance, are the same. There may be wide differences in the amount of time, work, worry—in the hour of the day or night between two such cases. Both, however, show up on the desk of the claims officer as "Gastric Resection, $300.00." Even wider variations may be found in internal medical care. A night spent with a diabetic in coma and a few minutes spent with an obviously lethal cerebral hemorrhage both may show up as a single hospital visit in the fee schedule. This is justifiably irksome to the physician who tries to set a value on his services according to the responsibilities and time involved in the particular case.

Ability to pay has been traditionally a factor in setting fees, he continued. Caring for the impoverished without charge has necessitated higher than average fees for the well-to-do. The application of this principle, however, has not always endeared the medical profession to the public. Though statistical proof is lacking, Dr. Crothers found that all physicians whom he had asked agree that there is not so strong a tendency to vary fees according to the economy status of the patient as at one time, and that these variations are within a smaller range. This is probably in part the result of acquaintance with fee schedules which are issued with insurance policies.

In his appraisal and comparison of indemnity and service benefits. Dr. Crothers stated that there are two conditions implicit in the advocacy of service benefits: (1) The fee should be one which recognizes the true value of the physicians' services, and (2) Service benefits should be limited to middle and low income brackets. We started out to render such services only to low income brackets. Changing economic conditions have produced a situation in which there really are no low income families among regularly employed persons. If we include organized labor groups in those eligible for service benefits, we have at once included middle income groups. And the strongest pressures for service benefits come from organized labor.

Dr. Crothers further stated that if the medical profession is to exert a vigorous influence in the development of prepaid medical care plans, its best opportunity to do so is through strengthening the physician-sponsored and controlled plans to the point where they are so sound, solvent and virile that they can prevent any combination of insurance companies from dominating the field.

Many other points of view—labor, legal, medical, administrative, etc.—were presented at this conference, and I was delighted that medical association executive secretaries were invited to attend this year. It is my belief that Hawaii Medical Service Association compares very favorably with prepaid medical service plans throughout the country, and I am glad I had an opportunity to learn more about the difficulties and successes encountered by such plans.

EDITH C. BENNETT
*Executive Secretary*
Hawaii Medical Association

# TERRITORIAL MEDICAL ASSOCIATION REPORTS

## AMERICAN MEDICAL ASSOCIATION SEVENTH ANNUAL CLINICAL MEETING

The Seventh Annual Clinical Meeting of the American Medical Association was held in St. Louis, December 1-4, 1953. The meeting was attended by some 7,500 people, including about 2,700 physicians. The scientific meetings and exhibits were held in the Kiel Auditorium, while the House of Delegates met in the Jefferson Hotel.

Your delegate arrived in St. Louis the night before the opening session, and made preliminary arrangements for distribution of 1,000 paper and 40 orchid leis generously provided by the Hawaii Visitors Bureau. In conjunction with AMA's promotional efforts sponsoring a post-convention tour to Hawaii after the San Francisco meeting next June, it was decided to concentrate these leis at social affairs for delegates and their wives. Highest priority was given the Women's Auxiliary Luncheon, which featured the Hawaiian theme and a colored travelogue on the Islands. This luncheon, attended by about 200 women, was a highly successful affair, and your delegate received, on behalf of our association and the Hawaii Visitors Bureau, a number of compliments and remarks of appreciation.

In the meetings of the House of Delegates, important policy actions were taken on social security, voluntary health insurance, medical ethics and unethical practices, medical education, hospital accreditation, military affairs and a wide variety of subjects affecting both physicians and the public. Highlight of the opening House session was the announcement that Dr. Joseph I. Greenwell of New Haven, Kentucky, had been selected by a special committee of the AMA Board of Trustees as the 1953 "General Practitioner of the Year." The annual medal and citation for community service by a family physician were presented to Dr. Greenwell by Dr. Edward J. McCormick, President of the AMA, who also gave his presidential address at the opening session. Dr. McCormick, in this address, made a strong appeal to the nation's physicians for "action that will further the full confidence of the public in our profession." "Good public opinion cannot be bought," he said. "It must be earned through exemplary conduct and genuine service in the public interest. Whatever money the AMA and its constituent societies spend for public education and public relations is wasted unless individual physicians take wholehearted interest in assuring the success of these ventures."

The opening day's program also included addresses by Dr. James R. Reuling, Speaker of the House of Delegates, and Dr. Chester Keefer, Special Assistant to Mrs. Oveta Culp Hobby, United States Secretary of Health, Education and Welfare. Dr. Reuling, emphasizing that much serious work remains to be done, warned that "times are just as troubled as when we had blanket bills before Congress which would have socialized the practice of medicine." Dr. Keefer told the House that "the voluntary way has been the most successful in the past and there is no reason to believe it will not continue to be in the future." He urged maximum effort, cooperation and leadership on the community level.

Reaffirming its opposition to proposed compulsory extension of Social Security coverage of physicians, dentists, and others self-employed, the House passed a resolution advocating passage of the Jenkins-Keogh bills now pending in Congress. These bills, providing for voluntary tax-deferred payments into retirement plans, were described as providing for "the development of a voluntary pension program which is equitable, free from compulsion, and satisfies the retirement needs of physicians."

Concerning medical care for dependents of military personnel, the House endorsed the Trustees' recommendation that where feasible, the military turn over dependency care to civilian doctors and hospitals, suggesting that servicemen rely on "the media of non-governmental insurance agencies to cover the cost of medical and hospital care of dependents through voluntary pay-roll deductions." In contrast, the non-service connected disability aspect of the veteran's medical care program received only passing mention in a Council report which recommended further regional studies.

To accelerate the development of voluntary health insurance, the House passed a resolution requesting an immediate study of the problems of (1) catastrophic illness coverage, and (2) coverage for retired persons. This resolution, pointing out the profession's responsibility to make every effort to promote prepaid medical coverage for all, cited these two large groups where improvements in prepaid plans could be effected.

In an effort to solve the adverse publicity problems resulting from unethical practices by a small minority of doctors, the House passed a resolution calling for a special committee's study, the results to be reported in the June, 1954, meeting. Similarly, an Iowa resolution asking for official approval of a joint-billing procedure where two or more physicians have rendered services, was referred for study to the Judicial Council.

To clarify misunderstanding among physicians regarding rules and regulations of the Joint Commission on Accreditation of Hospitals, especially as they concern the role of Departments of General Practice, the House passed a resolution requesting the Joint Commission to publish information in the Journal of the AMA and other official publications, to acquaint the medical-hospital profession with their regulations and interpretations, and to clarify methods of appealing those with which they are not in agreement.

In the field of medical education, the AMA's Board of Trustees announced its fourth grant of $500,000 to the American Medical Education Foundation, bringing its total contribution to two million dollars toward financial aid to the nation's medical schools. Simultaneously the Trustees warned that similar contributions could not be continued indefinitely without jeopardizing the AMA's financial status. It was therefore recommended that increased support of medical schools by individual physicians and medical and allied organizations be encouraged.

HOMER IZUMI, M.D.
*Delegate to A.M.A.*

# COUNTY SOCIETY REPORTS

## HONOLULU COUNTY MEDICAL SOCIETY

The Society held its regular monthly membership meeting at the Territorial Hospital on November 6, 1953. Dr. C. M. Burgess presided, with approximately 75 members and guests present.

An elegant Chinese dinner, generously provided by the Wyeth Corporation and excellently prepared by the hospital staff, was a highlight of the meeting.

Mr. James E. Howe of Wyeth Corporation presented an interesting account of his company's newly developed drugs.

Mr. Richard M. Kennedy, Executive Secretary of the Society and the Bureau of Medical Economics, was then introduced. He briefly discussed his recent mainland trip and future plans for the Society.

A resolution in memory of Dr. Francis J. ("Pete") Halford was duly adopted:

*Whereas,* Dr. Francis John Halford has been an outstanding member of the Honolulu County Medical Society since February 4, 1928, and served as its President in 1944; and

*Whereas,* Dr. Halford has been for more than a quarter of a century, and to his lasting credit, earnestly engaged in the care of the sick and injured of this community; and

*Whereas,* Dr. Halford has been a motivating force in the establishment and growth of the Honolulu County Medical Library, the Pan-Pacific Surgical Congress, and other worthy projects of community scope; and

*Whereas,* Dr. Halford died suddenly in San Francisco on October 1, 1953, at the age of 51 years; now be it therefore

RESOLVED, that the members of the Honolulu County Medical Society do hereby express their high regard for Dr. Halford, both personally and professionally, and do express their sympathy for the immediate family of Dr. Halford in their bereavement; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of the Society; and be it further

RESOLVED, that a copy of this resolution be transmitted to his wife, Mrs. Francis John Halford.

The meeting was then turned over to Dr. R. A. Kimmich, Medical Director of the Hospital, and his associates. They presented a very informative discussion concerning the modern concepts of psychiatric treatment.

* * *

The December meeting of the Society was held on the fourth at the Oahu Country Club. Dr. William S. Ito presided and approximately 85 members and guests attended. The usual presentation of scientific papers was omitted and there being no important society business to be transacted, the evening was devoted to social activities, including dinner, of a most agreeable nature.

R. C. DURANT, M.D.
*Secretary*

## KAUAI COUNTY MEDICAL SOCIETY

The regular meeting of the Kauai County Medical Society was held on October 13, 1953 at the G. N. Wilcox Memorial Hospital medical library. Dr. Ishii, president, called the meeting to order at 7:35 P. M. Members present were Drs. Wade, Brennecke, Masunaga, Cockett, and Fujii. Others present were Dr. Dodge, Mr. Moriarty, Drs. Kemp, Strongman, and Boyd.

Guest speakers were Dr. Dodge and Mr. Moriarty who presented a talk on the organization and facilities of the newly established Rehabilitation Center in Honolulu. A sound movie on the employment of the handicapped was also shown.

RICHARD M. YAMAUCHI, M.D.
*Secretary*

## MAUI COUNTY MEDICAL SOCIETY

A special breakfast meeting of the Maui County Medical Society was held on Sunday morning, October 25, 1953, with Vice-President Rockett presiding.

Those present were: Doctors Rockett, Izumi, Kashiwa, Kanda, Fleming, A. Y. Wong, Shimokawa, H. Kushi, Sanders, St. Sure, Underwood, Patterson and Reppun.

Guests were Doctors Rose, Mei, Faus, Herbert Chinn and R. O. Brown.

Dr. Reppun brought before the Society the problem or threat of a panel type of medicine proposed or contemplated on the Island of Molokai under union sponsorship. After a short discussion the matter was referred to the Board of Governors to investigate.

The rest of the meeting was turned over to Doctors Brown and Chinn. Dr. Brown presented a talk on hematuria, illustrated with case studies and X-rays. Dr. Chinn showed two movies on diagnostic procedures related to kidney studies. A question and answer period followed which was very instructive.

HAROLD S. KUSHI, M.D.
*Secretary*

# UMI MAKAHIKI I HALA*

## Procurement and Assignment

The Territory has already contributed 34 of its physicians to the armed services. Of this number 24 are from the Island of Oahu—7 Chinese, 2 Japanese, 16 Caucasians; from Hawaii, 1 Japanese; from Maui, 5 Caucasians; from Kauai, 2 Caucasians and 1 Japanese.

How many physicians can be spared from the Territory without seriously crippling the medical care of the civilian population? We have estimated this figure at 35 as a maximum.

## New Drugs

*New and Nonofficial Remedies, 1943.* Among the more noteworthy of the new additions are Nikethamide, the central nervous system stimulant which was first introduced as Coramine; Diethylstilbestrol, the synthetic estrogen; Trichinella Extract for the diagnosis of trichinosis; and Zephiran Chloride, a mixture of alkyl dimethyl benzyl ammonium chlorides, an interesting new anti-infective agent.

## Emergency Medical Services

In July 1943, the First Aid and Ambulance Division of the Emergency Medical Service reduced its monthly budget to approximately $15,000.00 from a monthly average of about $45,000.00, a reduction of $30,000.00. A considerable number of people were released thereby to enter other activities, but it is gratifying to note that a large percentage of this group has maintained a volunteer status at the first aid stations which they helped to operate during the tense defense period. At present only three first aid stations in the city continue to operate on a 24-hour basis. A few stations maintain skeleton staffs at night; all others are closed. The few "night" stations have limited their staff to a nurse and a nurses' aide who keep the station in a state of readiness to facilitate mobilization. As time goes on and the military situation develops more favorably, further alterations in this organization will be indicated.

*Maneuvers*

All-out maneuvers were held in the city last September and in the rural areas in November. A surprise maneuver in the city was staged in November. All agencies of the O.C.D. participated and the Army provided the incidents, making the test as realistic as possible.

Upon the completion of two years' activity, the Territory of Hawaii can rest assured that its Emergency Medical Service will continue to render efficient service and provide the maximum in civilian medical protection. Recent alerts and maneuvers have shown definitely that its personnel, as a result of their regular musters and training sessions, are capable of manning their posts efficiently and without confusion.

H. L. ARNOLD, SR., M.D.
*Territorial Medical Director*

## Hospital Needs

The present over-all per capita cost for a patient at Queen's is $8.50 a day. Ward rates for bed and board are $5.00. Bed and board in a private room in a convalescent-nursing home could probably be had for $5.00 or $6.00 per day and for less in wards.

## Honolulu County Medical Society

*Hospital Bed Shortage.*

Dr. Bowles reported meeting of Chamber of Commerce with medical society and hospital representatives and action that Chamber make a survey. Mrs. Bolles reported meeting of Public Health Committee, voting to make survey and using $2,500 already set aside for use of gathering preliminary data.

*C & C Patients.*

Resolution adopted by the Board of Supervisors and approved by Mayor was read, authorizing the C & C physician to pay to the Honolulu County Medical Society, through the various hospitals, amounts equal to 20% of hospitalization, not to exceed $12,000 annually.

* Ten years ago. From Volume 3, Number 3, January-February, 1944.

# NOTES AND NEWS

## PERSONALS

**Dr. and Mrs. Thomas Fujiwara** returned in November from an extensive medical tour of Japan. While in Tokyo, Dr. Fujiwara discussed the high incidence of cancer of the stomach among the Japanese with **Dr. M. Yamaguchi** of the Japanese Ministry of Health and **Dr. Y. Tazaki** of the Japanese Cancer Institute and Hospital and other medical leaders. Regarding the practice of medicine in Japan, Dr. Fujiwara says, "There are no courtesy privileges in any of the hospitals. If a doctor requires a hospital bed for treating his patients he has the choice of relinquishing his patient to a member of the hospital staff or of building his own little hospital. Hospital beds are generally very scarce and most doctors cannot afford their own hospitals. It certainly is not comfortable nor safe to become sick in Japan."

**Dr. Ernesto M. Santos** announces the opening of his office for the general practice of medicine and surgery at 315 South Kam Highway, Wahiawa. Dr. Santos was born in Pangasinan on the island of Luzon, P.I. He received his medical education at the University of Oregon Medical School. He interned at St. Vincent's Hospital in Portland, Oregon. From 1950 until 1953 he served with the United States Army in Korea, Japan, and Hawaii. Dr. Santos is married and has one daughter.

**Dr. Edmund L. Lee** announces the association of **Dr. Robert P. C. Ho** in the practice of medicine and surgery at 286 South Vineyard Street. Dr. Ho is a graduate of Temple University School of Medicine. He interned at Williamsport Hospital in Pennsylvania. Following this, he had specialized training in obstetrics and gynecology at Temple University Hospital. Recently Dr. Ho completed service on the house staff of St. Francis Hospital.

**Dr. Richard K. C. Lee,** President of the Hawaii Territorial Board of Health, attended the meeting of state and territorial public health officials at Bethesda, Maryland.

**Dr. Raymond F. Kong** announces the association of **Dr. Richard S. F. Lam** in the general practice of medicine and surgery at 1231 South Beretania Street.

**Dr. Garton Wall** has been elected President, **Dr. Alfred Burden** Vice-President, and **Dr. H. M. Chandler** Secretary-Treasurer, of the Territorial Association of Plantation Physicians.

Approximately 200 eye, ear, nose and throat specialists are expected to attend the 1954 annual meeting of the Pacific Coast Oto-Ophthalmologic Society in Honolulu. **Dr. C. W. Trexler** is in charge of local arrangements.

According to a news item in the *Honolulu Star-Bulletin*, **Dr. Sumner Price,** Medical Director of Queen's Hospital, is an able creative cook and is adept at baking a Holiday fruit cake. Those interested in the exact Rx should contact Dr. Price directly.

**Dr. H. McLeod Patterson** announces his association with **Drs. Bell and Bell** at 405 Dillingham Building with his practice limited to obstetrics and gynecology.

**Dr. Roy O. Ohtani,** a graduate of Tulane University and **Dr. Sidney T. Fujita,** a graduate of Temple University, presently serving with the United States Army, have been promoted to the rank of Captain.

The Medical Group announces the addition of **Dr. Clifford T. Druecker** to the staff of its Kaimuki office. Dr. Druecker is a graduate of Marquette University, Milwaukee, Wisconsin. He served his internship at The Queen's Hospital, Honolulu, and his residency in psychiatry at Milwaukee County Hospital. Following this, he served as Assistant Resident Physician at Kalaupapa Settlement. Dr. Druecker has recently completed three years of military service during which time he served as physician to the American Embassy in Saigon, Indo-China. Dr. Druecker is married and has one child.

**Dr. Glenn N. Yanagi** announces the opening of his office for the general practice of medicine at 338 South Vineyard Street. Dr. Yanagi took his undergraduate work at the University of Hawaii and received his BA from Columbia University. He received his MA, PhD, and MD from Harvard. Following graduation from medical school, Dr. Yanagi was engaged in cancer and biochemical research at the McArdle Memorial Laboratory for Cancer Research in Madison, Wisconsin. He served his internship at The Queen's Hospital, Honolulu.

**Dr. James G. Harrison** announces the opening of his office at 315 Royal Hawaiian Avenue with his practice limited to psychiatry. Dr. Harrison is a graduate of Duke University Medical School. He served his internship and residency at The Queen's Hospital, Honolulu, in psychiatry. Dr. Harrison also served as resident and staff psychiatrist at the Territorial Hospital, Kaneohe.

**Dr. and Mrs. Robert F. Bailey** announce the birth of their fourth child and third son, William Brooks, on October 29, 1953.

**Dr. Harry K. Takenaka** has been certified by the American Board of Pediatrics, has become a United States citizen, and has been commissioned as a Major in the Medical Corps of the United States Army.

**Dr. Ralph B. Cloward** returned from a 12,000-mile whirlwind tour of the mainland. During a five-week period, he addressed the International College of Surgeons in New York, the Orthopedic and Neurological Societies in Houston, the Society of Neurology and Psychiatry in Atlanta, the New York State Trauma Club in Syracuse, the Orthopedic and Neurological Societies in Chicago, the Mayo Clinic Staff in Rochester, the orthopedists and neuro-surgeons in Salt Lake City, the Western Orthopedic Association in Sun Valley, the American Academy of Neurological Surgery in Santa Barbara, and the Stanford Lane Hospital staff and Medical School in San Francisco. He discussed the subject of intervertebral disc and he performed disc operations before interested spectators in Houston, Chicago, Salt Lake City and San Francisco.

**Dr. Walter C. Alvarez,** medical consultant emeritus for the Mayo Clinic, was a recent visitor in the Islands. During his stay, Dr. Alvarez addressed the Territorial Association of Plantation Physicians and the Hawaii branch of the American College of Physicians. Dr. Alvarez first came to Hawaii in 1881. He lived in Waianae and Waialua until 1896. He graduated from Honolulu High School (now McKinley High School). He received his medical education in San Francisco. Following this,

he was assistant to Dr. Walter B. Cannon at Harvard. He joined the Mayo Clinic in 1926 and retired in 1950. He is now editor of "Modern Medicine" and is on the editorial staff of "Geriatrics and Gastroenterology." He is the author of a weekly syndicated medical column.

**Lt. Francis K. Won** has been awarded the Bronze Star Medal for meritorious service rendered as medical officer to the United States Army in Korea from January, 1953 to November, 1953.

**Dr. and Mrs. Andrew Ivy** announce the birth of their second child, a daughter, Patsy Mae, born on October 30, 1953.

**Mrs. Edith C. Bennett** attended the conference of State Medical Journal editors at the American Medical Association in Chicago in November, and also the Western Area Prepaid Medical Services Conference in San Francisco.

### Kauai

The Kauai County Medical Society had the pleasure of honoring **Dr. Walter C. Alvarez** at a dinner at the Kauai Inn on November 18, 1953. Following the dinner, Dr. Alvarez presented a talk on his many interesting medical experiences.

**Dr. Eichi Masunaga,** Kauai's own physician-artist, exhibited his art accomplishments at the Lihue Library on December 6, 1953. Dr. Masunaga's paintings and metal work were recently exhibited in Honolulu.

### Maui

**Drs. William Patterson, Edward Shimokawa** and **Alfred Burden** attended the annual Territorial Plantation Physicians convention held on Molokai.

Another boy has been added to the family of **Dr. and Mrs. Shimokawa** and another girl added to the family of **Dr. and Mrs. Ohata.**

**Dr. Maxwell Boyd** is associated with **Dr. R. J. McArthur** in the practice of medicine. Dr. Boyd was with **Dr. Wallis** on Kauai before coming to Maui. Welcome to Dr. Boyd.

**Dr. and Mrs. Edmund Tompkins** returned from the Mainland after a well earned vacation in the Northwest. We were rather worried about the reports of the number of hunters that were shot at during the opening of the hunting season. Dr. Tompkins wasn't so fortunate; he didn't get any hunter.

## NEWS

### New Hawaii Chapter
### American College of Chest Physicians

Local members of the American College of Chest Physicians had a meeting at Leahi December 21 with Dr. Seymour M. Farber who is a Regent of the California American College of Chest Physicians, and organized a Hawaii Chapter of the American College of Chest Physicians. Officers of the Hawaii Chapter are:

*President*.....HASTINGS H. WALKER, Honolulu
*Vice President*.....WILLIAM F. LESLIE, Hilo
*Secretary-Treasurer*.....FREDERICK L. GILES, Honolulu

They plan to have regular meetings and stimulate discussion by presenting cases pertaining to diseases of the chest as often as it is feasible.

### Postgraduate Conference in Ophthalmology

Stanford University School of Medicine will present the annual postgraduate conference in Ophthalmology from March 22 through March 26, 1954. Registration will be open to physicians who limit their practice to the treatment of diseases of the eye; or eye, ear, nose and throat. In order to allow free discussion by members of the conference, registration will be limited to thirty physicians.

Programs and further information may be obtained from the Office of the Dean, Stanford University School of Medicine, 2398 Sacramento Street, San Francisco 15, California.

### National G.P.s' Meeting

The American Academy of General Practice makes the first official announcement of its Sixth Annual Scientific Assembly which will be held March 22-25, 1954, in Public Auditorium, Cleveland, Ohio, by disclosing the names of such topflight men as Sir Alexander Fleming, Dr. Howard Rusk, and Dr. E. J. McCormick who are headlining the scientific program.

### Chest Disease Course

The Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the respective state chapters of the College as well as the staffs and faculties of the local hospitals and medical schools, will sponsor the Second Regional Postgraduate Course on Diseases of the Chest in New Orleans, Louisiana, February 15-19, 1954 and the Seventh Annual Postgraduate Course on Diseases of the Chest to be held at the Bellevue-Stratford Hotel, Philadelphia, Pennsylvania, March 15-19, 1954.

Further information may be secured by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

### Chest Physicians to Meet

The American College of Chest Physicians will meet at the Fairmont Hotel in San Francisco, June 17-20, 1954, and the Third International Congress on Diseases of the Chest is to be held in Barcelona, Spain, October 4-8, 1954.

### Medical Service Representatives of Hawaii

September 1953 marked the formation of the Medical Service Representatives of Hawaii. The membership of this newly formed organization is derived from representatives of the following pharmaceutical manufacturers here in the Territory:

| | |
|---|---|
| Abbott Laboratories | Ayerst, McKenna & Harrison, Ltd. |
| E. R. Squibb & Sons | Ethicon Suture Laboratories |
| Eli Lilly and Company | Ortho Products |
| Lederle Laboratories | Warner-Chillcot Co. |
| Mead Johnson & Co. | S. E. Massengill |
| Parke, Davis & Company | A. H. Robins Co. |
| Pfizer & Co., Inc. | Hoffmann-La Roche Inc. |
| Schering Corporation | Ciba Pharmaceutical Co. |
| Upjohn Company | Winthrop-Stearns, Inc. |
| Wyeth, Inc. | Sharp & Dohme, Inc. |

Their newly elected officers are:

*President* .....R. C. RODGERS
*Vice-President* .....H. PETERSON
*Secretary* .....N. IFVERSON
*Treasurer* .....E. EHLKE
*Directors* .....V. E. CANNON
A. B. SMITH
S. H. CUNNINGHAM

# The Problem of Nausea and Vomiting:

## ITS TREATMENT WITH DRAMAMINE®

Whenever nausea, vomiting and vertigo are disturbing and complicating factors, Dramamine may be used with confidence.

Keats[1] outlines the wide list of conditions in which Dramamine (brand of dimenhydrinate) has proved valuable as follows: "It has been well established in the control of motion sickness. It has been used effectively in the prevention and treatment of seasickness, airsickness, [in the treatment of] the nausea of pregnancy, Ménière's syndrome, . . . radiation sickness . . . and postfenestration reactions. . . . The site of action is imperfectly understood, but there is indication of an action of depressing labyrinthine function or its neural pathways, a highly selective central action, or both. Few side reactions of this drug have been noted."

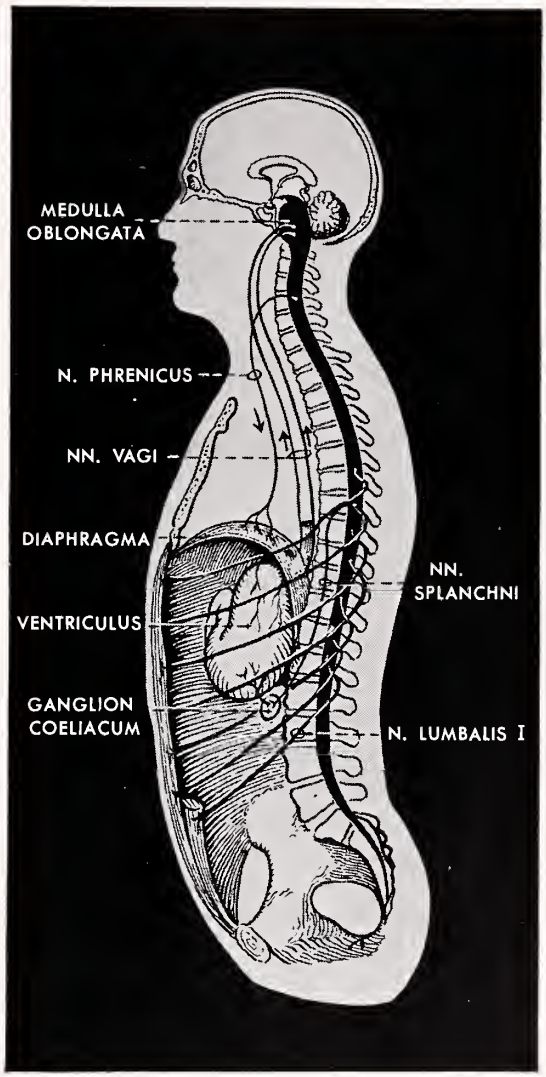
The usual dose for motion sickness is 50 mg. (one tablet) taken one-half hour before departure and, if necessary, before meals for the duration of the journey. Control of nausea and vomiting of other conditions and severe motion sickness is achieved, with minimal drowsiness, by a dosage of 100 mg. every four hours.

"[Dramamine] is administered orally or rectally. . . . The same doses may be administered rectally by insertion of the tablet or other suitable form. . . ."[2]

Dramamine Liquid is particularly useful for children.

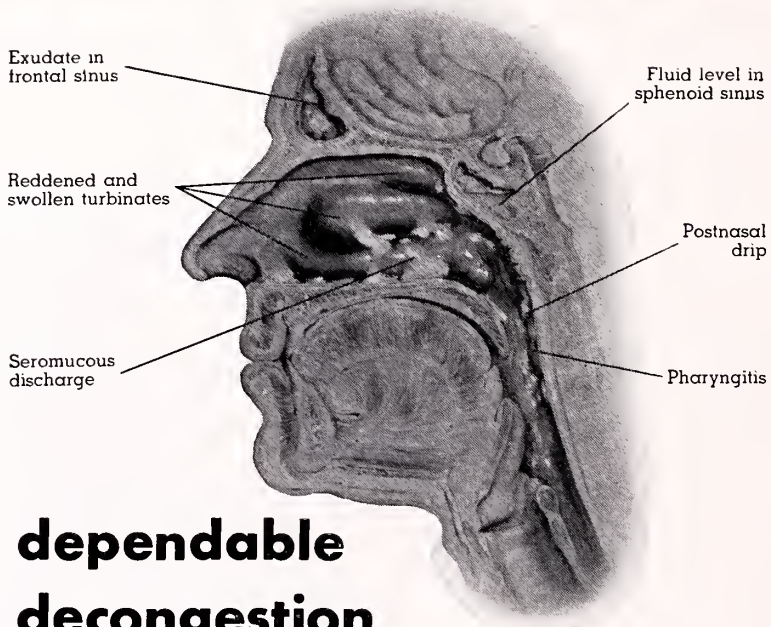
Dramamine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Keats, S.: Ataxic Cerebral Palsy with Akinetic Seizures: Dramatic Response to Dramamine, J. M. Soc. New Jersey *50*:53 (Feb.) 1953.
2. Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1953, Philadelphia, J. B. Lippincott Company, 1953, p. 471.




THE VOMITING REFLEX: *Vagus→ nodose ganglion→ solitary tract→ spinal cord→ cervical, thoracic and lumbar nerves to diaphragm, cardiac sphincter, stomach, abdominal and pelvic musculature. (After Krieg, W. J. S.: Functional Neuroanatomy, ed. 2, New York, The Blakiston Company, Inc., 1953, p. 104.)*

SEARLE *Research in the Service of Medicine*




# dependable decongestion

## *in colds, sinusitis, allergic rhinitis*

Through its prompt and prolonged decongestive action Neo-Synephrine not only restores nasal patency during all stages of the common cold, sinusitis or allergic rhinitis, but also helps to reestablish and protect the physiologic defense mechanisms of the nasal cavity: and encourages proper sinus drainage and aeration.

Neo-Synephrine's powerful vasoconstrictive action is exerted with virtually no sting, congestive rebound, or systemic side effects and is undiminished after repeated use.

# NEO-SYNEPHRINE® Hydrochloride

Brand of phenylephrine

*Rapid and Sustained Relief*

¼% solution (plain and aromatic), 1 oz. bottles
½ and 1% solutions (when stronger vasoconstrictive action is needed), 1 oz. bottles
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NEW YORK 18, N. Y. WINDSOR, ONT.

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAMS, *Executive Secretary*, Honolulu

BULLETIN COMMITTEE

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LILLIAN CHONG, Kauai — JUDITH MAGARIFUJI, Maui

## PRESIDENT'S MESSAGE

Nineteen fifty-three is gone, and most of 1954 is before us. In retrospect, 1953 was a good year; 1954 promises to be even better. New programs have been established, and new policies put into practice. The Territorial Legislature was generous with us—$15,000 for scholarships in spite of a new economy program. We had a convention on Maui. Total cost of this venture was work for the Valley Islanders. No money was spent by the Association. We increased the number of Board members by seven section chairmen, members who offer a real contribution to this group.

Hard working committees accomplished a tremendous amount of work for the Association, much of it not manifest on surface examination. For example, through the efforts of the Margaret Jones Memorial Fund Committee, we now have a signed indenture with the Bishop Trust Company making this a trust fund. This is a business-like arrangement which provides for the best management of this sizable sum. The Practical Nurse Committee guided the practical nurses through the difficulties of forming a Territorial Association. Through the work of the Legislation Committee the Legislature continued the Commission on Nursing Service and Nursing Education for another biennium. This Commission has recently begun a study of nursing functions. These are only a few of the progressive steps taken through the work of committees.

Good committees are the backbone of a useful, smooth-running association. When you have an hour or two, you should review the annual reports prepared by committee chairmen which were presented at the recent convention. It is a remarkable exposition of your association at work. It may help you to answer the old question: "Why should I join the Nurses' Association?"

We are grateful to all those committee members who worked so hard in 1953. We are indebted to those who have chosen to accept the chairmanship of certain committees for another year. We are proud of the committees which have been set up for 1954.

ELIZABETH S. MCCALL, R.N.
*President*

## MARION W. SHEAHAN, R.N. DIRECTOR OF THE DIVISION OF NURSING SERVICES (NLN)

Marion W. Sheahan, R.N., who has been closely identified with the development and progress of nursing in the United States for the past 30 years, is associate director of the National League for Nursing and director of its Division of Nursing Services. The Division includes the Department of Hospital Nursing and the Department of Public Health Nursing.



MISS SHEAHAN

As teacher, author and executive, as well

as professional nurse, Miss Sheahan has helped guide the destinies of the growing nursing profession. She is the only person not a doctor ever to receive the Lasker Award, which the American Public Health Association gave her in 1949. The citation said: "Her comprehensive program for nationwide action in the field of nursing became the blueprint which initiated and will guide progress in nursing for many years."

Miss Sheahan's leadership in nursing also was recognized with her selection as one of 15 members of the recent President's Commission on the Health Needs of the Nation.

As director of the New York State Bureau of Public Health Nursing from 1932 to 1948, she pioneered new methods of public health nursing that set a pattern for her own and many other states.

Miss Sheahan is a graduate of St. Peter's Hospital, Albany, New York. Early in her career she did public health nursing at the Henry Street Settlement in New York. She has received an honorary degree of Doctor of Humanities from Adelphi College, New York.

## HAWAII LEAGUE FOR NURSING

### ANNUAL MEETING

The first anniversary of the Hawaii League for Nursing was celebrated all day on November 24. The convention was attended by fifty league members.

The League for Nursing is organized around the central belief that good nursing for all our people can come through community planning and unified community action.

Action was taken to streamline organizational structure by giving up the cumbersome "two division pattern" which in the past year took so much of our energies in the organization effort involved and had hindered program development. Next year we will have special interest committees which members can join on a voluntary basis: a Committee on Administration (subcommittee on Careers); a Committee on Education (subcommittee on Measurements); a Committee on Medical and Surgical Nursing; Committee on Maternal and Child Health; Committee on Operating Room Nursing; and other committees of special interest areas can be formed. This committee set-up should stimulate participation by the "grass-roots" nursing practitioners in public health and on the general staffs of hospitals, who are needed badly in the League membership if the League is to make its contribution to the improvement of community nursing services and toward the education of nurses who can carry out the newer concepts of nursing. For example, the Committee on Medical and Surgical Nursing will need the combined strength of hospital and public health nurses as it studies what is needed to improve nursing services and nursing preparation in this area. The potential membership for the League is great when one considers the hospital administrators, former patients, social workers, and teachers who have a vital concern with how well the community is nursed. In the revised constitution provision is made for a new class of associate members (at $3). Committees may include non-members.

Our distinguished guest, Miss Marion Sheahan, Director of the National League for Nursing Division of Nursing Service, spoke on League services: "Through programs which draw in public-spirited citizens, other agencies concerned with better health, organized nursing services, nursing educators, and nurses in all fields, state leagues pool their resources and plan to meet their nursing needs. The National League gives state leagues the advantage of country-wide experiences and contacts.

"All over the mainland and the territories nurses and non-nurses are working on such activities as: the best possible education for professional and practical nurses; recruitment of students; helping hospitals and public health agencies to use personnel more efficiently; coordinating community services so that people receive essential nursing in home, clinic as well as in hospitals; extending care to patients at home; keeping the public informed of available nursing services.

"The National League in turn serves the local leagues through activities which can be carried on more economically and efficiently at national level to give guidance to the country as a whole. Standards and goals for nursing services and education are established. Accreditation of programs in nursing education is carried on as a means toward improvement. Other services include: books, pamphlets, and guides of many kinds; consultation services provided through correspondence and personal visits; maintenance of a public information program about nursing; representations of nursing on many national committees.

"You in Hawaii are not so greatly distressed as is the mainland because of the great imbalance between supply of nurses and demand. I have learned that all budgeted positions in Hawaii can be filled except in a few rural locations, and that nurses are available for whom no positions are waiting. I hear, too, that you have enough applicants for your basic schools of nursing. This is highly important for the quality of student taken into our

nursing schools is an important factor in meeting the nursing needs of the near future. These needs are growing in quantity but more so in the degree of skill and understanding which modern nurses must possess as compared to the decade past."

Two dramatizations of nursing practice of yesterday, and nursing practice of today demonstrated the great changes that have taken place in a period of twenty years in nursing responsibilities. The discussion which followed pinpointed these changes as: changes in medical science such as the use of antibiotics and early ambulation; better diagnostic procedures, which make possible earlier diagnosis; the fact that nurses now perform technical functions formerly done by doctors; the old concept that everything must be done for the patient has given way to the concept that the patient and family do better by sharing more responsibility for care; the appearance of several new kinds of personnel on the nursing team means that the patient has contact with more persons; the patient is under care a much shorter period of time and the nurses' working day is shorter which means less time to really become acquainted with him and his problems; and the broader concept of care today which embraces continuity between hospital and home care, rehabilitation and such programs as prepayment insurance plans.

For nursing education these changes mean: a more careful selection of students of mature status who can develop the judgments required; the professional student needs to be prepared to lead the nursing team of today; both the rapid patient turnover and the team concept mean that increased skills must be developed in the area of interpersonal relationships through basic nursing preparation, and through inservice education; the educational process involved in the assumption of care by the patient himself means that the nurse must understand why and how people learn; and finally the concept of total care extending beyond the confines of the hospital ward means that nurses must be prepared to fully utilize community resources.

For nursing services these changes mean: reallocation of functions and better utilization of personnel; dynamic inservice education programs; that the nurse must see that the continuity of care is insured after the patient leaves the hospital in terms of referral to appropriate community services.

At a luncheon meeting of the League attended by ten hospital administrators and school of nursing committee members, Miss Sheahan stated that it was important that hospitals relate their nursing services to other community agency services; that admission chest x-ray programs, immunization programs, and well baby conferences should be developed.

She also stated that there are 334,000 active and 220,000 inactive registered nurses. Approximately 50 per cent of the latter are under 50 years of age and should be encouraged to return to nursing to help relieve the shortage existing on the mainland.

She revealed the fact that from nursing function studies being made it seems that 50-70 per cent of nursing activities today are within the realm of daily living activities, while only 30-50 per cent involve technical aspects of nursing. This indicates a need to use the 370,000 nonprofessional nursing personnel to better advantage. It also emphasizes the need for good judgment by the registered nurse in determining the needs of the patient and assigning the appropriate nursing team member to the specific job for which he is prepared. It also points to the need for staff meetings and improved inservice education programs to help each member of the nursing team to understand his or her function on the team.

Improvement in nursing education has been brought about by the closing of small schools of nursing and a greater development of schools with better teaching and clinical facilities. In 1880 there were 2,200 schools of nursing while now, in 1953, more student nurses are being educated in the 1,100 schools. Miss Sheahan stated that if more of the small schools consolidated, it is felt that probably 700 schools of nursing may be sufficient to educate the number of professional nurses needed. Nurses themselves must decide whether the two or three year program is needed to meet future nursing needs, however, there is general agreement today that the four year program is here to stay.

Elected to the Board were:

Miss Virginia Jones, President
Mrs. Sara Jane Trainovich, Treasurer
Mrs. Patience Martelon
Capt. Margaret Hollinger
Miss Mary Neal

Committee on Nominations:

Miss Karen Tanaka
Mrs. Alice Imada
Mrs. Emilia Centeio

## INTERDIVISIONAL COUNCIL FOR OCCUPATIONAL HEALTH NURSING

The Interdivisional Council for Occupational Health Nursing was organized on June 22, 1953, in Cleveland, Ohio, following approval by the National League for Nursing's Board of Direc-

tors. This action was based on petitions received from the industrial nurse members of NLN.

Unanimously elected as chairman and vice chairman for a two year period were Mary Louise Brown of New Haven, Connecticut, and Teresa M. Gorman of Minneapolis, Minnesota.

The recommendations presented by the Council to the NLN Board of Directors were twofold: (1) That the Board appoint a committee to be charged with the responsibility of investigating the needs of industrial nurses and of suggesting how these needs can be met within the framework of NLN, of investigating ways and means of integrating the fundamentals of Occupational Health Nursing into the basic curriculum and for establishing criteria of accreditation of these areas in the basic nursing curriculum, of investigating and developing a curriculum of specialization for nurses in Occupational Health at the graduate level and necessary criteria for accreditation and of planning ways of interesting industrial nurses in becoming members of NLN and of helping to establish Interdivisional Councils in state Leagues. (2) That an industrial nurse serve on the NLN's curriculum and evaluation committee and on other standing committees of the NLN.

The NLN committee is to be composed of representatives from the fields of occupational health nursing, general nursing education, occupational medicine, and industrial management and labor. A further suggestion was that a subcommittee made up of an industrial nurse, industrial nursing consultant, and an occupational health nursing educator be created to offer consultant service to the NLN Board and staff on Occupational Health Nursing until an occupational health nurse is a member of the NLN staff.

## ACTION OF YOUR BOARD OF DIRECTORS

November 13, 1953

*Approved* minutes of House of Delegates NATH annual meeting; minutes of the Advisory Council meeting; and minutes of the pre-convention Board of Directors meeting.

*Heard* that no NATH funds were spent for the annual meeting and there was a profit of $32.69.

*Accepted* (upon recommendation of Margaret Jones Memorial Fund Committee) the indenture submitted by our attorney making Margaret Jones Memorial Fund a trust fund with Bishop Trust Company as trustee.

*Appointed* Mrs. Marjorie Okinaka to replace Miss Rose Littel who resigned as Maui's representative on the NATH Board of Directors. She will serve the remainder of the term (1951-1954).

*Changed* salary schedule of Executive Secretary from P4, second step, to GS11, second step.

*Requested* Personnel Committee to review the personnel policies and study salaries of the two NATH employees and report to first 1954 meeting of the Board.

*Set* tentative dates for 1954 Board meetings: March 12, June 18, and preconvention.

*Accepted* Rules for Special Groups Section and proposed revisions for Public Health Section.

*Requested* NATH sections to prepare their 1955 budgets early in 1954 for use of NATH Finance Committee.

*Decided* to set up a special committee to study the need and possible function of an International Relations Committee.

*Appointed* committees and special representatives for this year. (See list of chairmen elsewhere in this section.

*Dissolved* the Practical Nurse Committee.

*Appointed* Harriet Kuwamoto to attend the Economic Security Workshop to be held in December by ANA.

*Discussed* membership poll to be taken in January relative to the assignment of bargaining for nurses to the Nurses' Association.

*Requested* districts to submit to NATH office names of nurses from which the Board may choose the three members at large to serve as representatives to the ANA Biennial. If these are sent, NATH will need to finance. Each section is also entitled to one representative.

The President, Mrs. Elizabeth McCall, announced that she would attend the ANA Advisory Council in New York in January. She also appointed the Executive Secretary to represent NATH in the Human Relations Workshop offered by the Oahu Health Council in January.

## NURSES' ASSOCIATION, TERRITORY OF HAWAII, INC.

### NEW COMMITTEE CHAIRMEN

Appointed by Board of Directors in November

STANDING COMMITTEES:

| | |
|---|---|
| *Arrangements:* | Rachel Kong (Hale Mohalu) |
| *Constitution & By-Laws:* | Leona Rubbelke (Dept. of Health) |
| *Finance:* | Lawrence Katsuyama (Kuakini) |
| *Legislation:* | Myrtle Schattenburg (Practical Nurse School) |
| *Margaret Jones Memorial Fund:* | Marjorie Elliott (Practical Nurse School) |
| *Membership:* | Margaret Nott (Kapiolani) |
| *Nominations:* | Emilia Centeio (Dept. of Health) |
| *Nursing Information:* | Loretta Schuler (Territorial Hospital) |
| *Program & Arrangements:* | Alice Scott (Dept. of Health) |

SPECIAL COMMITTEES:

| | |
|---|---|
| *Counseling & Placement:* | Mary Marshall (Children's) |
| *Economic Security:* | Harriet Kuwamoto, Consultant (Dept. of Health) |
| *Inter-Island Bulletin:* | Toshiko Ono (Dept. of Health) |
| *Library:* | Angela Stempel (University of Hawaii School of Nursing) |
| *Practical Nurse:* | Grace White (Leahi) |

SPECIAL REPRESENTATIVES:

| | |
|---|---|
| *Board of Management, Mabel L. Smyth Memorial Building:* | Lois Bell (Liberty House) |
| *Treatment & Rehabilitation Committee of the Citizens Council on Narcotics Control:* | Paula Sorg (Dept. of Health) |
| *American Red Cross Nursing Services Committee:* | Isabel Medeiros (Leahi) |
| *Scholarship Committee, Honolulu Chapter National Foundation Infantile Paralysis:* | Suzanne Medeiros (Dept. of Health) |
| *Committee on Survey and Assignment of Health Personnel, Territorial Civil Defense:* | Alison MacBride (Dept. of Health) |
| *Oahu Health Council:* | Martha Rothwell (Dept. of Health) |
| *Personnel Committee:* | Margaret Rodearmel (Leahi) |

## A HISTORY OF PUBLIC HEALTH NURSING IN HAWAII*

The earliest kindergartens in Honolulu (around 1897) showed the need of service to children and this came as volunteer work at first from Mrs. Ulrich Thompson, former nurse whose husband taught at Kamehameha School. For nearly 10 years, Mrs. Thompson performed remarkable service not only for the kindergarten, but for the entire Palama neighborhood. She visited all kindergartens twice each week and made innumerable house calls to follow up her cases and give instructions in home nursing, cleanliness and diet. She was the predecessor of the district nurse later provided by Palama Settlement.

### 1900-1909

In 1905, when Palama Chapel changed its name to Palama Settlement, a study of the neighborhood revealed the need for home nursing care and health instruction. To provide this service the Settlement employed a part-time nurse to make afternoon home visits. As the value of this service came to be recognized, more nurses were employed. Gradually the program combined free dispensaries, baby conferences, pre-natal clinics, school nursing, and supervision of tuberculosis patients.

### 1910-1919

When the Bureau of Tuberculosis was established in the Board of Health in 1910, it was authorized to employ two nurses to be assigned to Palama Settlement for general nursing with special attention to the detection of tuberculosis cases.

In 1911, nine graduate nurses were making home visits. The following year, the nurses were visiting kindergartens to give health supervision and treatment. In 1914, eight nurses worked in Honolulu under the direction of Palama Settlement, and Kauai and Hawaii each had one nurse. Maui and rural Oahu got their first Board of Health nurse in 1916.

The first Nurse Practice Act in Hawaii was passed in 1917. That year, the two nurses "returned" from Palama to the Board of Health Tuberculosis Bureau. These two nurses did only tuberculosis follow-up while the Palama nurses, in their generalized program, carried all services except tuberculosis.

In 1919, the first school nurses were employed and there was one nurse employed on each island.

### 1920-1929

In 1921, the Board of Health had nine nurses —two each on Oahu, Hawaii, and Maui, and three on Kauai. During this decade the number of nurses employed gradually increased so that by 1929 there were 31 public health nurses.

In 1922, Miss Clara Figeley became supervisor of nurses upon her appointment as assistant director of the Bureau of Tuberculosis. The following year, the title of "Tuberculosis Nurse" was changed to "Public Health Nurse," whose duties included social service work as well as school and tuberculosis nursing. The annual report of the Board of Health for 1924 carries the first separate report of public health nursing activities.

The public health nursing program at that time included school nursing, communicable disease control, social work, nutrition, infant welfare, and tuberculosis. The tuberculosis control budget provided funds for public health nursing activities.

California Packing Corporation's Wahiawa pineapple plantation employed its first field nurse in 1922. She visited the homes of plantation workers to follow-up medical recommendations and teach parents the fundamentals of nutrition, infant and child care. The health of plantation workers in both the sugar and pineapple industries had been a major concern of the employers from as early as 1905 when reports indicated plantations provided medical care. The system led to the employment of graduate nurses known by various titles such as field nurse, camp nurse, plantation nurse, or visiting nurse.

* By Esther M. Stubblefield, Public Health Nursing Supervisor, Bureau of Public Health Nursing, Department of Health, Territory of Hawaii.

The passage of the Shepherd-Towner Act in 1925 saw the establishment of the Bureau of Maternal and Infant Hygiene in the Board of Health the following year. Additional nurses employed through funds provided by this Act were known as "supervising child hygiene nurses."

The first course in public health nursing in 1926 at the University of Hawaii consisted of a series of lectures by persons interested in health and social work. In September, 1927, a generalized public health nursing program went into effect throughout the Territory, except in Honolulu. This program included maternal and infant hygiene, work in the schools, tuberculosis and orthopedic nursing, and social service.

Miss Figeley resigned as nursing supervisor in 1927, to be replaced by Miss Mabel Smyth. A year later Miss Smyth, who held the combined positions of director of the Bureau of Maternal and Infant Hygiene and supervising public health nurse, recommended a separate Bureau of Public Health Nursing, and a medical director for the Bureau of Maternal and Infant Hygiene.

In 1929, the Board of Health and Palama Settlement nursing staffs pooled their resources to offer better public health nursing service to the community and initiated a generalized program in Honolulu. At the close of this decade, 13 of the 31 Board of Health nurses had public health training. However, there was no difference in salary for nurses, regardless of whether they had received public health training or not.

(To be continued in next issue)

## CORRECTION OF ERROR IN THE AMERICAN JOURNAL OF NURSING

There was a printer's error in the article, "Diet and Nutrition During Pregnancy" as it originally appeared in the November 1952 issue of "The American Journal of Nursing."

The error is in paragraph 2, page 1379, of the Journal and page 2 of the reprint, and reads as follows: "For example, the caloric requirement increases approximately 45 per cent, calcium 50 per cent, and riboflavin 75 per cent." The correct statement reads, "For example, the caloric requirement increases approximately 20 per cent while the need for protein is increased approximately 45 per cent, calcium 50 per cent and riboflavin 75 per cent."

Excellent opportunity for nursing instructor in teaching students on Truk. Two year contract. Travel expenses paid. If interested, call or write your Professional Counseling and Placement Service, 510 South Beretania Street, Honolulu; telephone 6-8630.

## LIFE ON AN ATOLL

Mrs. Mary Lew, R.N., sent Christmas greetings to the members of the Nurses' Association again from Majuro in the Marshall Islands 2,500 miles beyond Honolulu.

She stated that there was little of the competitive commercialism and rush of Christmas shopping in the village, there being only a few general country stores that "sell odds and ends of most anything." Sears Roebuck, however, does a tremendous business by mail with the island population. As for other resources in terms of service and merchandise, there is a barber shop, and a commissary where a good supply of canned goods and frozen meat are available. No dry cleaners, tailors, shoe repair shops, florists, or beauty parlors!

Mrs. Lew reports that though the area is tropical it is a healthful district. Heart trouble, high blood pressure, ulcers, and psychoses are rare, as well as nose and throat troubles. Tuberculosis is quite prevalent, diabetes exists, fractures and accidents occur, and of course there is considerable maternity work.

During the summer a native doctor returned qualified to operate on cataracts. Mrs. Lew states he has literally opened the eyes of the blind. Many afflicted have come from near and far in big boats, little boats, and by any means of transportation at hand—some, kings and chiefs from the outer islands. The old go home grateful to be able to see better. The increase in the surgical work load, she states, has been a real challenge to the staff, particularly maintenance of sterile supplies (her function) when at any time the autoclaves may break down.

Recreation for the Marshallese consists largely of swimming, fishing, and boating, though they also enjoy baseball and picnics. Land travel is by means of bicycle, and some mechanized putt-putts which appeared recently. On Sundays at church one sees bicycles rather than cars.

The forty-five Americans in the area comprise the government colony, and are concerned primarily with schools, public health, and community management. One pleasant innovation initiated by the Americans, Mrs. Lew reports, is the "moonlight sail." Boats are chartered for the whole of the evening during the full of the moon. Supper is served aboard, and there is singing, the musical crew joining in. It is moonlight in pure culture, no neon signs or street lights to compete.

Mrs. Lew closed her letter saying that this summarizes life on an atoll.

## NURSING FUNCTION STUDIES

The Commission of Nursing Service and Nursing Education has begun a study of nursing functions starting with a pilot study at Leahi Hospital. It is hoped that this will be a part of the five year program of studies being conducted by ANA.

Dr. Douglas Yamamura, Assistant Professor of Sociology, University of Hawaii, is in charge of the study. He has on his working team three graduate students, one having a major in psychology and the other two in sociology. All are trained in research methods.

Upon the completion of the pilot study, the Commission will review the results and determine whether or not further studies should be carried on in other hospitals.

## ECONOMIC SECURITY WORKSHOP

Miss Harriet Kuwamoto attended an ANA workshop on economic security in New York City in December. The theme of the workshop was "Cornerstones for an Economic Security Program" with emphasis on the concepts of democracy in a modern society and the techniques to be used in improving employment conditions for nurses through group action.

The ANA paid travel expenses.

## CONVENTION NEWS

The ANA Biennial Convention will be held in Chicago, April 26-30, 1954, at the Conrad-Hilton Hotel. The convention theme is "Calling American Nurses to Action."

The Nurses' Association, Territory of Hawaii, Inc. is entitled to representation at biennial conventions or special meetings of the American Nurses' Association on the basis of one delegate for every 200 active members of each section or fraction thereof, such delegate or delegates to be elected in a manner to be determined by the section. Each section, through the Nurses' Association, Territory of Hawaii, Inc., shall certify the names and addresses of the delegate or delegates and their respective alternates elected for such section. The number of delegates is computed on the number of active members of each section of the Nurses' Association, Territory of Hawaii, Inc. in good standing in the ANA on December 31 of the year preceding a biennial convention or special meeting. Each section of each district nurses' association will be asked to submit to the secretary of the corresponding territorial section a list of nominees for delegates and alternates to the biennial convention or special meeting.

The Nurses' Association, Territory of Hawaii, Inc. is entitled to 3 delegates-at-large to biennial conventions or special meetings of the American Nurses' Association, these being selected by the NATH board of directors from names submitted by the districts.

Hawaii is therefore entitled to 10 delegates; 7 section delegates, and 3 delegates-at-large. The current problem is—how can they be financed?

## STATE BOARD EXAMINATIONS

One hundred thirteen graduates from Queen's and St. Francis Hospital Schools of Nursing took the National League for Nursing Test Pool Examinations in September. Each student took six examinations: communicable disease, obstetric, medical, surgical, pediatric and psychiatric. The only examination failure was in obstetrics.

## NADO BAZAAR

"Fun and Food for the Whole Family" is the theme of the big money making project of the Nurses' Association, District of Oahu.

A bazaar will be held on Friday, February 5, and Saturday, February 6. There will be lots of space for everyone as it will be held on the lanai of the Mabel Smyth Building and the lawn of the Queen's Hospital and in the Queen's Hospital School of Nursing classroom.

This second annual bazaar will have many interesting booths. They are as follows:

*Food:* Delicious saimin and tasty barbecue, hot dogs, soft drinks, shaved ice, coffee and doughnuts, homemade jams, jellies, pies, cakes and cookies.

*Unusual Gifts* (white elephants): Books, linens, records.

*Clothing* for men, women, children and infants.

*Plants* such as herbs, orchids, ti, cactus, anthuriums, etc., to give you many hours of joy.

*Character reading and hand writing analysis.*

*Special:* Check stand for bulky purchases.

General chairman is Mrs. Gladys Leong (telephone 6-5748), assisted by co-chairmen Mrs. Esther Stubblefield (business telephone 7-1921) and Mrs. Leila Miyamoto (telephone 6-6419).

Sub-committee chairmen and their telephone numbers are as follows:

*Food:* Lawrence Katsuyama—6-2236.
*Unusual gifts:* Dorothy Burtch—5-5981 and Ramona Kimura—6-2236.
*Clothing:* Mabel Gordon—5-5981
*Plants:* Mrs. Grace White—7-1901.
*Inter-school council and games:* Alberta Conchee—6-3551, room 202.
*Character reading:* Mrs. Marjorie Elliott.
*Script:* Mrs. Joan Shelton—5-4563.
*Finance:* Mrs. Helen Williams—7-1921
*Publicity:* Loretta T. Schuler—24-2191.

**Nurses and friends:** We need your help. Please bring in your old and usable clothes for all ages and both sexes; bring all kinds of plants and select items of handiwork. Cakes, cookies and pies are needed. Remember the bazaar February 5 and 6.

Could you plan your time to help in a booth? We need many willing hands for a successful bazaar.

Plan to have a meal or two with your family at our bazaar.

There will be bargains, fun and food for all. Do tell your friends about our bazaar.

LORETTA SCHULER, R.N.

## DISTRICT OF OAHU NEWS

Nurses' Association, District of Oahu, has employed a part-time office clerk, Mrs. Sue Miyashiro. She works three hours a day, five days a week, from 9 to 12.

* * *

Miss Elsa Graupner, R.N. retired from Children's Hospital in February, 1953, after working there as a supervisor for 18 years. A tea was given in her honor by the nurses of Children's Hospital.

Miss Graupner graduated in 1912 from Lebanon Hospital, New York City, following which she did private duty nursing there and in Hartford. She also worked as a supervisor in hospitals in both cities.

Upon her retirement to Kalae, Molokai, over one hundred of her friends attended a welcoming party given by Mrs. Mary Adamek at the Orchid Lounge.

Miss Graupner has been a member of the Nurses' Association since 1935. We all congratulate her upon

her years of service and wish her many years of enjoyable living.

* * *

Miss Olga Larson, on exchange with Virginia Vogel from Fairlawn (New Jersey) High School, is finding her experience very interesting. She is near enough that she can visit her family frequently, and she is thoroughly enjoying the opportunity to see new shows and plays. She sends you all her Aloha.

Miss Vogel, whom many of you met at the Annual Meeting, is also enjoying her experience at Farrington High School. Both nurses feel that more such exchanges should be planned.

* * *

Miss Mary V. Cheek, Director of Nursing, The Queen's Hospital, has accepted a position as Director of Nursing Services at North Carolina Memorial Hospital, University of North Carolina, Chapel Hill, North Carolina, with a rank of Associate Professor on the university faculty. She came to Honolulu in 1949 after serving as Director of Nursing in Memorial Hospital, South Bend, Indiana. She has her master's degree in nursing administration from the University of Washington, Seattle.

Miss Cheek has served actively in nursing association work in the following capacities: member of Board of Directors, Vice President and Chairman of the Advisory Committee of the Nursing Service Bureau, Nurses' Association, District of Oahu; and Chairman of the Nursing Service Administrators Section, Nurses' Association, Territory of Hawaii, Inc. She served two years on the Board of the Oahu Tuberculosis and Health Association; was a member of the Professional Advisory Committee to the Health Committee of the 1950 Holdover Committee of the Legislature; and was Vice President and President of the Hawaii League of Nursing Education. Outside of professional activities, she was a member of Zonta International.

Miss Cheek started her new position on January 1. Our best wishes go with her.

Miss Audrey J. Booth, who has been Assistant Director of Nursing for two years, has been appointed Acting Director.

## NURSES' ASSOCIATION COUNTY OF KAUAI

Two of Mahelona Hospital's nurses became engaged: Miss Hilda Nemoto to Allen Michioka and Miss Esther Nakamae to Motomi Shigeta.

Mrs. Presentacion Runes and Mrs. Esther Konno have returned to the staff of Mahelona Hospital.

After completing a four-month postgraduate course in surgery at Johns Hopkins Hospital, Miss Edith Yamagata returned to work at Wilcox Memorial Hospital on December 1. Miss Yamagata was employed at Mt. Sinai Hospital in New York before coming home.

Miss Virginia Bloomquist, who was formerly a member of the Nurses' Association, County of Kauai, prepared an elaborate wardrobe for a doll which was raffled off at a nurses' tea on December 7.

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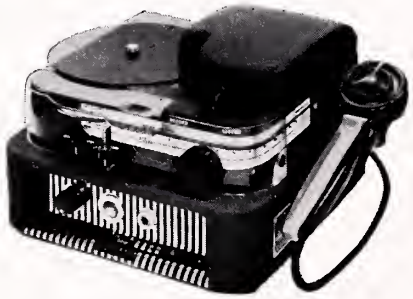
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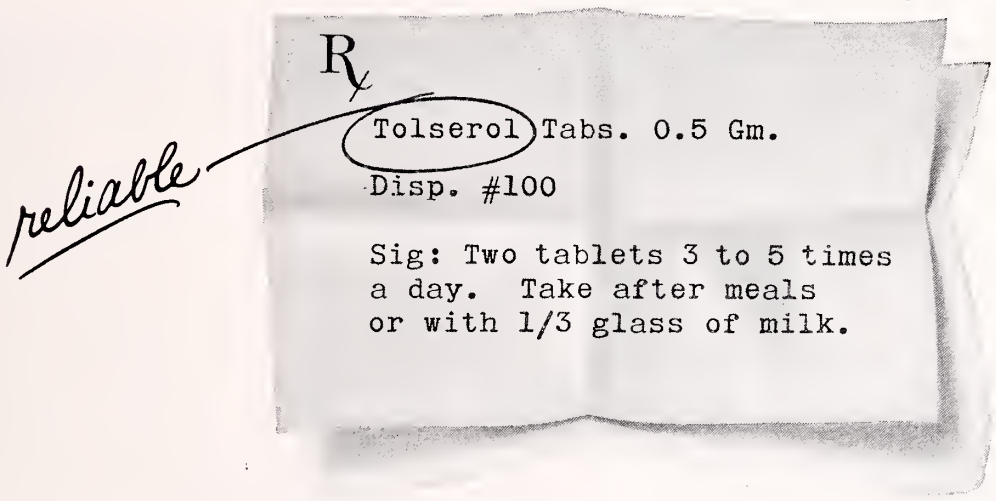
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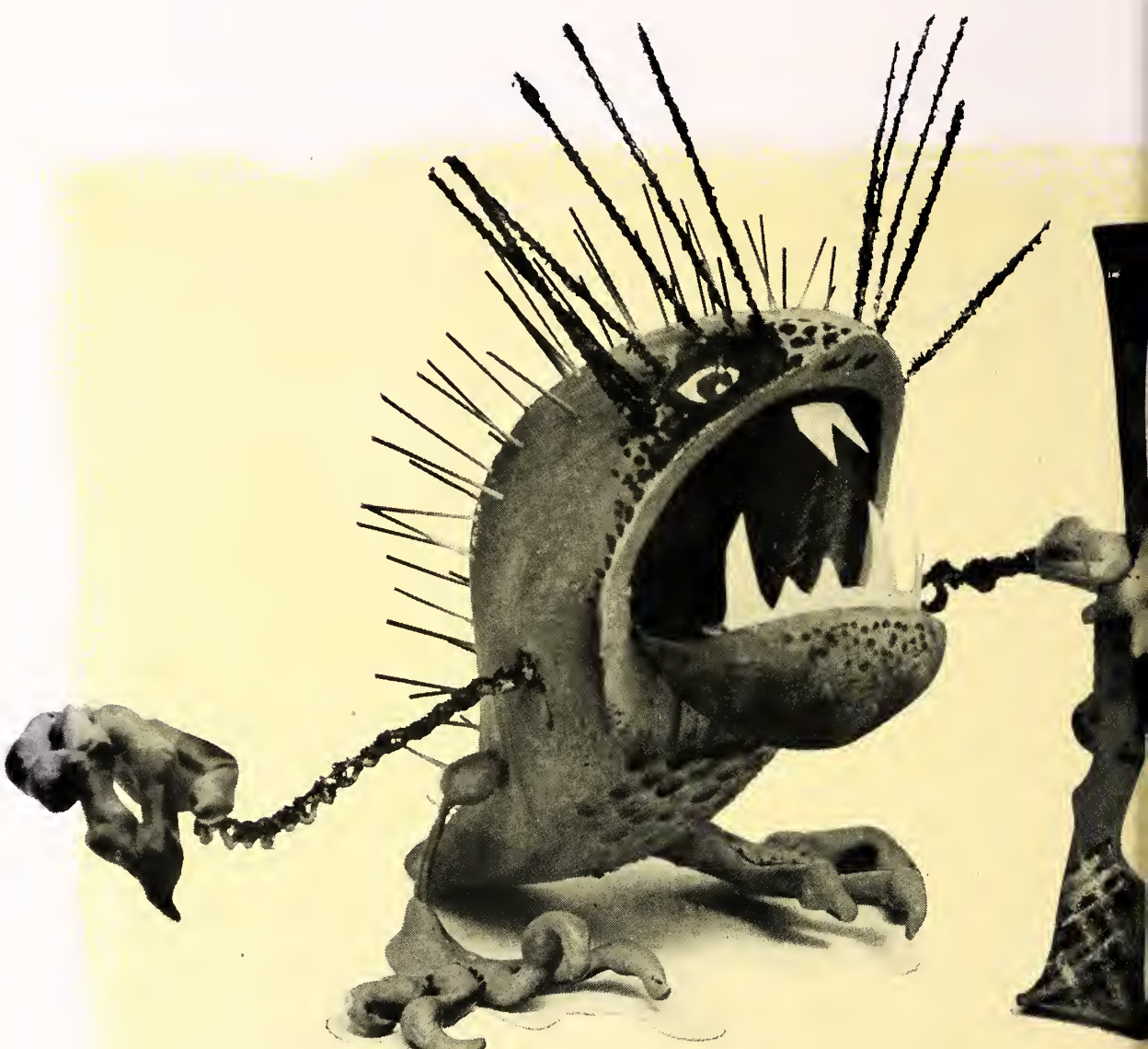
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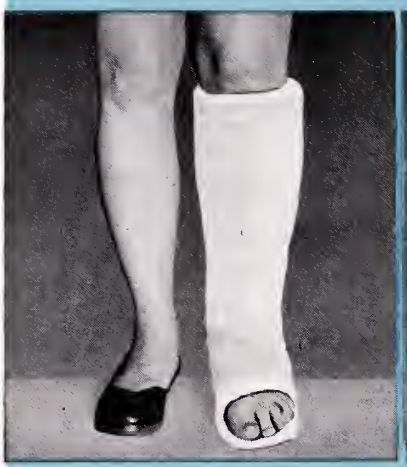
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# Melmac* Orthopedic Composition

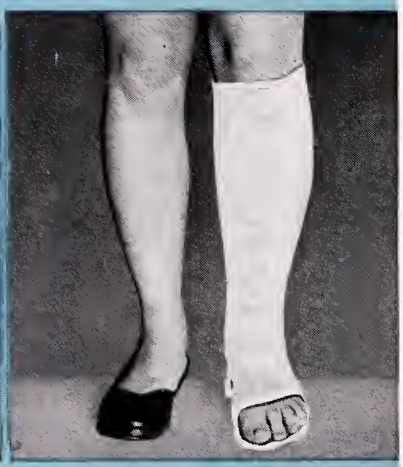
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**Note:**

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*references:*

1. A. W. Spittler, Col., (M.C.), U.S.A., J. J. Brennan, Lt. Col., (M.C.), U.S.A., J. W. Payne, Capt., U.S.A.F. (M.C.), American Academy of Orthopedic Surgeons, Jan. 26-31, 1952, Chicago, Illinois.
2. M. C. Cobey, M.D., F.A.C.S., Professor of Orthopedic Surgery, Georgetown University and Senior Attending Orthopedic Surgeon, Children's Hospital, Washington, D.C., The American Surgeon, Vol. XVIII, No. 4, April, 1952, pp. 413, 415.
3. M. C. Cobey, M.D., F.A.C.S., Washington, D.C., private communication.



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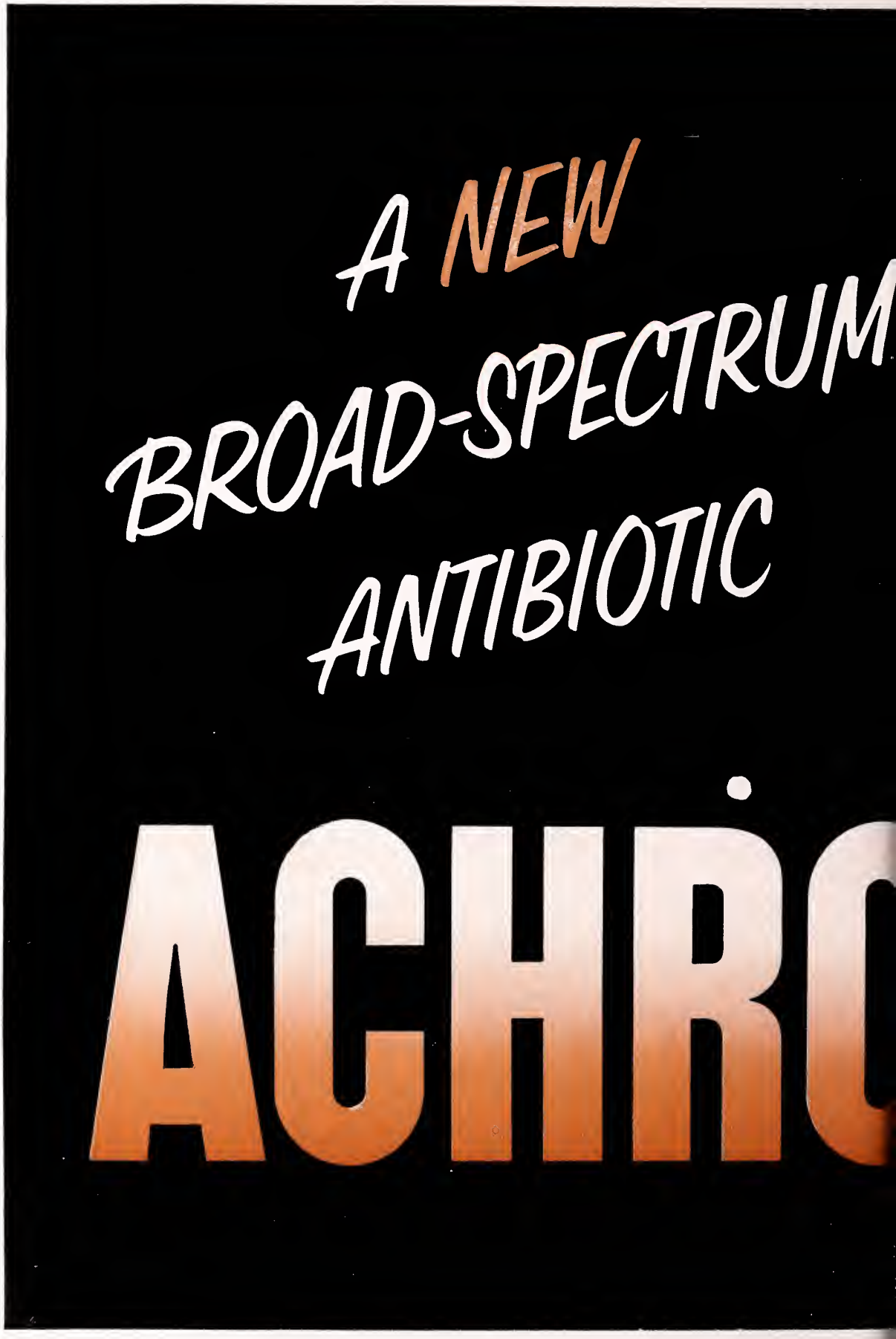
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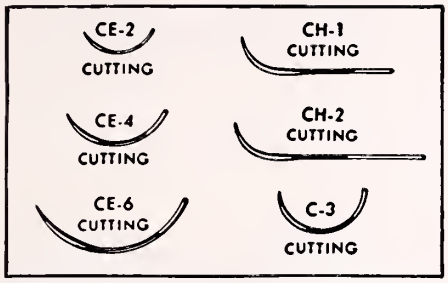
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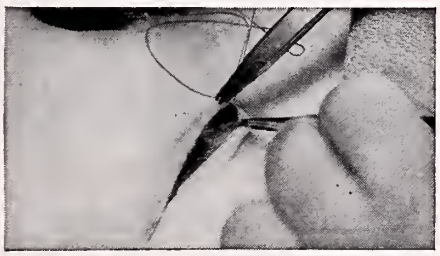
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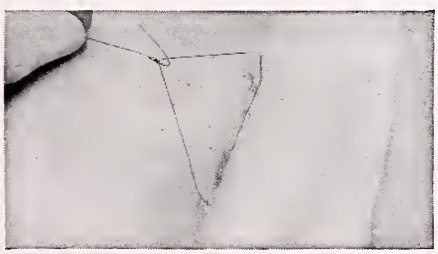
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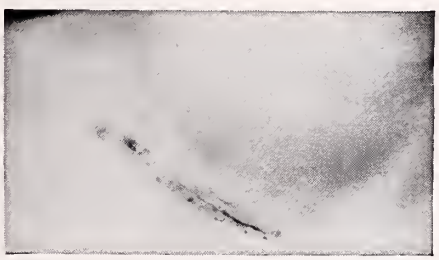

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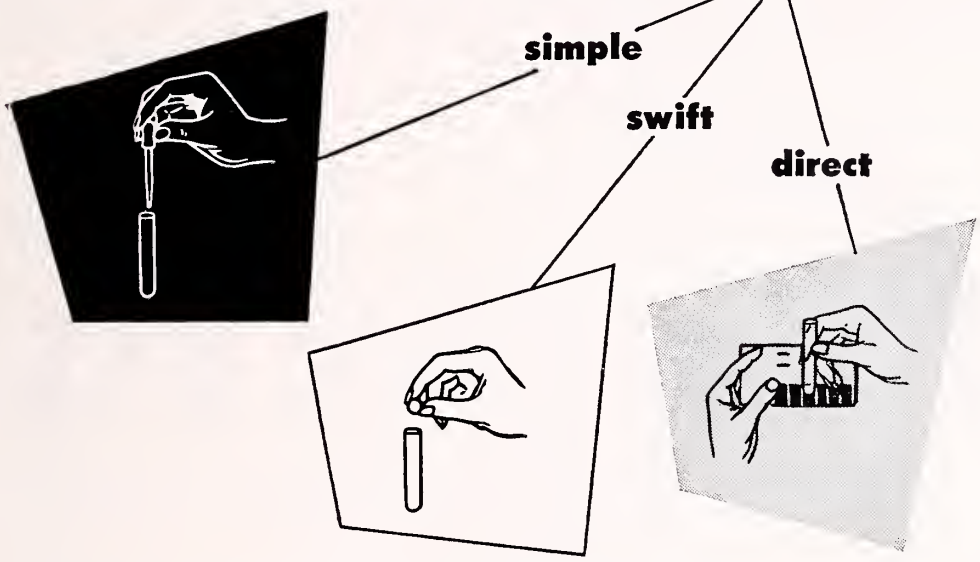
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Volume 13
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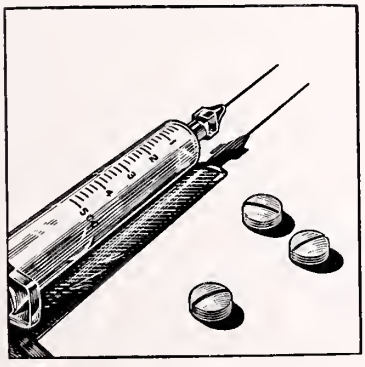
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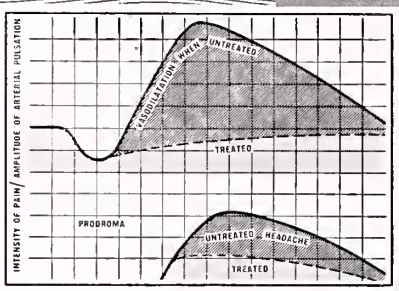
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1. Sayer, R. J., et al.: Am. J. M. Sc. *221*:256 (Mar.) 1951.
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*Downing, J. G. et al.: J.A.M.A. 133:299, 1947. Shipley, E. R. et al.: Surg. Gynec. & Obst. 84:366, 1947. Wawro, N. W.: Connecticut M. J. 12:17, 1948. McCollough, N. C.: Indust. Med. 16:128, 1947. Long, P. H.: A-B-C's of Sulfonamide and Antibiotic Therapy, Philadelphia, W. B. Saunders, 1948, p. 152. Meyer, J. H.: J. Internat. Coll. Surg. 13:748, 1950.

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3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

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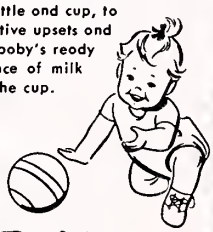
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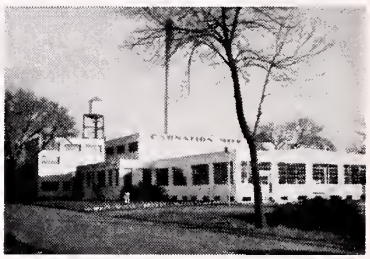
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# ENDOMETRIAL CARCINOMA

## Report of Five Cases

FRANK C. SPENCER, M.D., Honolulu

ENDOMETRIAL CARCINOMA is generally considered to be a disease of the menopausal and post-menopausal group, not infrequently associated with obesity, diabetes mellitus and hypertension. It occurs one-fourth to one-third as frequently as carcinoma of the cervix, is of a lower grade of malignancy, and does not metastasize as rapidly. It produces prodromal symptoms earlier, and in general is not such a treacherous disease as squamous cell carcinoma of the cervix.



DR. SPENCER

Five cases of endometrial carcinoma, seen in my private practice in the past four years, illustrate some of the problems in the diagnosis and treatment of this disease.

### Case Reports

CASE 1. When this moderately obese Japanese patient, age 31, was first seen, she had been flowing twice a month for the past two months, and for a few months previous to that had been spotting after her regular menstrual periods. Her only hospitalization had been for delivery four and one-half years earlier.

Examination revealed a rusty mucoid discharge from the external os; the fundus was anterior, normal in size and freely movable. The adnexa were negative. The vaginal smear showed cells suspicious of endometrial carcinoma.

One week after the first visit endometrial biopsy was done in the office with a biopsy curette. A soft abundant area of tissue could be immediately felt in the wall of the left side of the uterus with the curette. The pathologist reported endometrial carcinoma, Grade I.

Three days later, under sodium pentothal anesthesia, a more thorough curettement was done and two 50 mg. tubes of radium in tandem in rubber tubing were placed in the fundus of the uterus for a total 3,125 milligram hours.

One month after the radium application a total hysterectomy and bilateral salpingo-oöphorectomy was done and eight days later X-radiation was started. A total of 8,000 r through four pelvic portals was given. The pathology report on the surgical specimen was: "atrophic endometrium with a necrosis of the uterine wall, secondary to radium therapy."

CASE 2. This obese Japanese patient, age 49, had had a definite diagnosis of endometrial carcinoma established nine years previously (Fig. 1.). The treatment had been intracavitary application of 100 mg. of radium for a total of 7,200 milligram hours and 1,800 r of X-radiation through one anterior pelvic portal 20x20 cm. She had been well and free of symptoms until one week before when she had noted vaginal spotting.

On examination the cervix was found to be slightly eroded and the fundus in posterior position, normal in

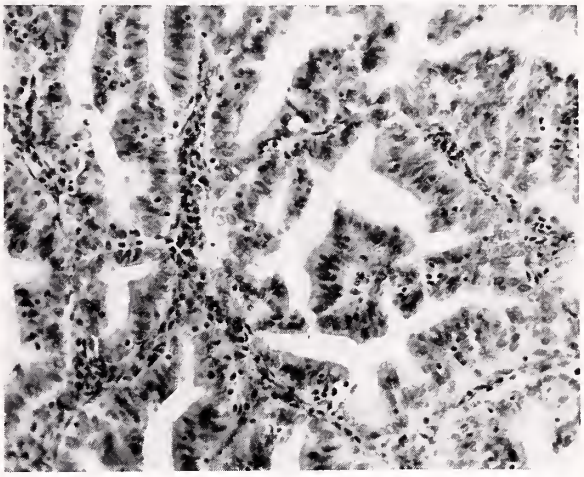


FIG. 1 (Case 1). Photomicrograph of endometrial biopsy done in 1940. The microscopic appearance is that of well differentiated adenocarcinoma. Hematoxylin and eosin, X 200.

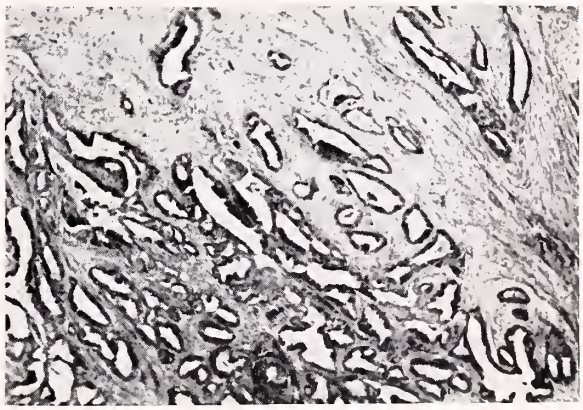


FIG. 2 (Case 2). Photomicrograph, low power, to show widespread infiltration of the uterine wall by the carcinoma. This infiltration extended almost to the serosa. Hematoxylin and eosin, X 35.

Read before the Sixty-Third Annual Meeting of the Hawaii Territorial Medical Association, Wailuku, Maui, May 1, 1953.

size and freely movable. The parametria and adnexa were negative. The vaginal smear was negative for malignant cells.

Curettement and cervical biopsy were done in the hospital three days later. Very little endometrial tissue was obtained even with forceful curettage. The pathologist reported: "cellular activity and cellular changes of a border line character," and suggested repeat curettage. Since I had curetted until muscle fibres were present in the microscopic sections, and in view of the previous history of the disease and the mode of therapy, it was decided to go ahead with surgery.

A total hysterectomy was done and infiltrating adenocarcinoma of the uterus (Figs. 2 & 3) was reported by the pathologist.

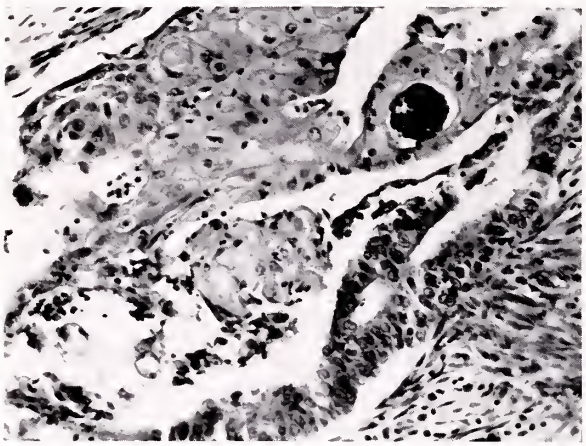


FIG. 3 (Case 2). Photomicrograph to show squamous metaplasia which was found in many areas. Note squamous elements above and glandular epithelium below. Hematoxylin and eosin, X 200.

CASE 3. This 72 year old slender Caucasian patient was referred because of occasional episodes of vaginal bleeding. No vaginal bleeding was noted. There was atrophic vaginitis, and a few punctate spots were noted on the cervix. The vaginal smear was typical of the early crowded menopause, rather than the deep menopause which might be expected in an individual of this age. No cells suspicious of malignancy were noted.

She was placed on estrogen cream therapy for the senile vaginitis and asked to return if she had recurrence of vaginal bleeding. During the next two years she was seen six times; not until the last visit was any bleeding seen, and the vaginal smears were always negative for malignant cells. When the bleeding was noted she was sent to the hospital and curettement and cervical biopsy were done. Very little endometrial tissue was obtained with the curette, and I regretted subjecting such a dear old lady to that procedure.

To my surprise the pathologist reported adenocarcinoma of the endometrium, Grade II. Eight days after the diagnostic curettage she was again hospitalized and two 50 mg. tubes of radium in tandem in rubber tubing were inserted in the fundus for 3,600 milligram hours. Three weeks after application of the radium a total hysterectomy and bilateral salpingo-oöphorectomy were done.

The pathologist reported: "adenocarcinoma of the endometrium, Grade II, treated with radium. There is evidence of minimal infiltration of the malignant process into the myometrium. There are small areas of squamous metaplasia of the endometrium."

CASE 4. This patient, a Filipina, age 42, had had normal menstrual cycles until seven weeks previously. Since that time she had been flowing constantly and had passed small clots three days before. What appeared to be normal menstrual blood was exuding from the external os. The body of the uterus was slightly and symetrically enlarged. The adnexa were negative.

Curettement was done in the hospital the next day. There was nothing grossly abnormal about the tissue obtained but the pathologist reported: "endometrial carcinoma in menstruating endometrium" (Fig. 4).

Eight days after curettement a total hysterectomy and bilateral salpingo-oöphorectomy were done. She had an uneventful recovery, except for bleeding from the vaginal cuff two weeks after surgery. This was controlled by vaginal packing and transfusion with one unit of blood.

The pathologist reported: "multiple sections taken from widely separated points covering the entire endometrial cavity show residual foci of slight but definite atypical endometrium remaining. This atypical endometrium is characterized by hyperplasia with marked pseudo-stratification of epithelial cells. In a few places the atypical glands superficially invade the underlying myometrium. In other areas, the endometrium appears benign and the usual proliferative basalis type. Residual in situ endometrial carcinoma."



FIG. 4 (Case 4). Photomicrograph to show picture of adenocarcinoma. The malignant glandular epithelium shows definite secretory activity manifested by vacuoles within the cells, a very unusual findings. Hematoxylin and eosin, X 200.

CASE 5. This moderately obese Caucasian patient, age 45, had had two previous hospitalizations, once for delivery and again for appendectomy and resection of the right ovary fifteen years previously. She was a registered nurse, and quite cancer-conscious.

Pelvic examination was essentially negative. The fundus was anterior, firm and slightly enlarged but smooth and regular in outline. The vaginal smear was negative for malignant cells. Her last menstrual period had been at the regular interval about six weeks before, but about two weeks later there had been another episode of bleeding of ten days' duration.

Since she was entering the hospital for saphenous vein stripping, it was decided to do a curettement at the same time. Grossly the tissue thus obtained appeared normal but the pathology report stated: "this endometrium is quite atypical even for the menopause stage, when atypical endometrium is to be expected. Whether this is just a marked atypical reaction or an early carcinoma is difficult to say. It is probably the latter" (Fig. 5).

Two weeks after curettement a total hysterectomy and bilateral salpingo-oöphorectomy were done. No carcinoma was found in the surgical specimen. Even so, the pathologist said, "I am glad we did more for this patient than just a curettement."

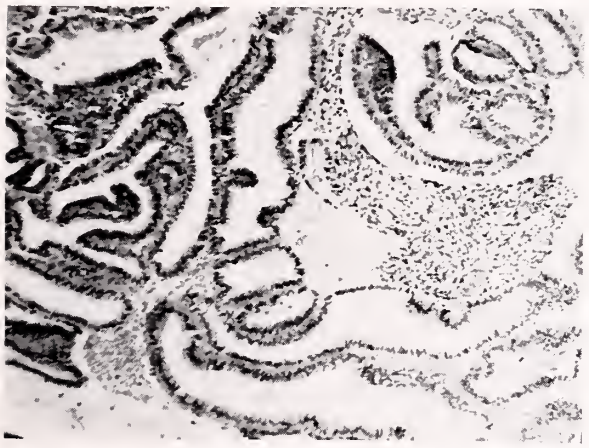


FIG. 5 (Case 5). Photomicrograph to show atypical endometrium. Is it early carcinoma or is it adenomatous hyperplasia? Not all pathologists would agree on either diagnosis. Hematoxylin and eosin, X 100.

## Comment

### *On the Diagnosis*

Any irregular vaginal bleeding in the menopause period should be suspect until it is proven that the carcinoma is not present. The so-called "functional bleeding" patient should not be treated medically until malignancy is ruled out. Thorough curettement should be done in the hospital. I find sodium pentothal an excellent anesthesia for this purpose, and the hospital stay can be limited to not more than twenty-four hours. This is a comparatively cheap and safe procedure for the protection that is afforded the patient. Curettage has the further advantage that it will cure about 50% of the cases of "functional bleeding" without further therapy of any type.

The vaginal smear is not of great value in the diagnosis of endometrical carcinoma. The cells of this tumor are not shed as early or often as are those of the epidermoid carcinoma of the cervix. The smear should be taken by aspiration of the endocervical canal as well as by scraping the squamous-columnar junction of the cervix at a time when there is some evidence of vaginal bleeding. A positive finding is very helpful but a negative finding is of no value, as negative findings are not at all uncommon when this tumor is present. If a positive smear is found the diagnosis may be confirmed by office biopsy; otherwise a more thorough curettement should be done in the hospital.

### *On the Treatment*

At the present time there is no complete agreement on the value of preoperative irradiation. In the words of Novak, this is a "rather confused and fluid problem." There are two schools of thought—some do and some don't. Statistically, the therapeutic results are about the same for each group. To this occasional operator it seems we might be guided somewhat as follows: if the tumor is a highly malignant one, or if the uterus is large enough to indicate that the tumor might be deep in the myometrium or even beyond, preoperative radiation should be used. On the other hand, if the lesion seems to be more localized, then complete surgical removal of the uterus, tubes and ovaries should suffice.

The use of postoperative X-radiation should be guided by the findings at surgery and the report of the pathologist. If there seems to have been complete surgical removal, then we should not burden the patient with the hazard and expense of X-ray therapy.

Surgery should include complete removal of the uterus, both tubes and both ovaries. I believe in the conservation of ovarian tissue, but in this circumstance there can be no compromise. The ovaries must be sacrificed, however young the patient may be, as this type of tumor frequently and early extends out to the ovaries.

Dogmatic statements about clinical problems do not always hold true. Fair, fat, and forty may be suspect of gall stones, but lean brunettes of less than forty may also be victims of that disease. And so it is also with carcinoma of the endometrium. In the cases here presented there was no associated diabetes; three were obese, one hypertensive and only one in the post-menopausal age group. Carcinoma, like gold, is where you find it; and we should never forget to suspect and to look.


## Acknowledgment

Dr. Irvin L. Tilden made the photomicrographs and I am indebted to him for these and the legends accompanying them.



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# TUBAL STERILIZATION IN THE HUMAN FEMALE

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FERTILIZATION of the ovum normally occurs in the uterine tube. The fertilized ovum is then propelled into the uterine cavity by tubal peristalsis and ciliation. Implantation takes place upon the endometrium, usually high on the anterior or posterior uterine wall. Pathologic factors that prevent proper descent of the ovum or cause implantation in the lower uterine segment will only be acknowledged here, since they constitute other distinct topics. But the fact that the tube is the site of conception leads to the obvious conclusion that any alteration which prevents the union of the two germ cells in that structure renders the woman sexually sterile.



DR. BACHMAN

## Methods

Several general surgical approaches have been designed to destroy the continuity of the tubal canal.[1] The first and most simple is tubal ligation. This is done by a direct tie around the tube, usually in the proximal third of its length, using either absorbable or non-absorbable ligatures. Variations of this basic technique are (a) a double tie, one in the proximal third with the other at the juncture of the ampulla and fimbria, and (b) a tie around a loop of tube, the loop usually consisting of the middle third of the structure.

Tubal resection is another method. This is accomplished by simple removal of a given segment of the tube, ordinarily in the middle third, and tying off the two remaining free ends. Excision of the uterine cornu containing the interstitial portion of the tube is also employed and is known as cornual resection. The isthmus of the tube is removed at the same time, and the free end buried between the leaves of the broad ligament.

Salpingectomy, either complete or partial, is likewise advocated. Complete salpingectomy means what it says. Partial salpingectomy can take the form of amputation of the fimbria or of the fimbria and the distal half of the tube, leaving a blunted end that usually scars over later.

Combinations of these three methods, namely, tubal ligation, tubal resection, and salpingectomy, are frequently used, although either of the last two alone is sufficient if properly done; so the operator who chooses a combined approach can name his own variety.

From the standpoint of time relationships, sexual sterilization can be puerperal or postpartum, interval, incidental, or concomitant. If it is done within seventy-two hours of delivery, it is puerperal or postpartum sterilization. If done without relation to recent pregnancy, it is interval sterilization. If done along with another procedure such as colporrhaphy, uterine suspension, diastasis recti repair, etc., it is incidental sterilization. If done with cesarean section, hysterotomy, or therapeutic curettement, it is concomitant sterilization. In these last instances, it is considered a separate operation, however, linked in title with the primary effort, and designated as cesarean section-sterilization, hysterotomy-sterilization, therapeutic abortion-sterilization, etc.

When first popularized about fifteen years ago,[2] puerperal or postpartum sterilization was limited by suggestion to that done within twenty-four hours of delivery, and, even though that arbitrary limit was a personal imposition, many people still consider that to be the proper definition. The fact is, however, that puerperal sterilization can be done within seventy-two hours of delivery and still be accurately puerperal. After seventy-two hours, the secondary developments of the puerperium appear, so sterilization done in the interval from the fourth to the fourteenth postpartum day would be technically intrapuerperal. I suggest, therefore, that that terminology be used, if one insists upon splitting the definition.

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Read at the regular monthly general staff meeting of Kapiolani Hospital, September 17, 1953.

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[1] Dickinson, R. L. and Gamble, C. J.: Human Sterilization, Birthright, Inc., Princeton, 1950. Lee, J. G., Randall, J. H., and Keettel, W. C.: Tubal Sterilization, Am. J. Obst. & Gynec. 62:569 (Sept.) 1951.

[2] Adair, F. L. and Brown, I.: Puerperal Sterilization, Am. J. Obst. & Gynec. 37:472 (Mar.) 1939.

### Indications

The indications for sexual sterilization are divided into absolute and relative categories. Absolute indications exist in the presence of severe, progressive cardiac, pulmonary or renal disease; in systemic conditions such as refractory syphilis, primary anemia, malignancy, congenital or post-traumatic disability; in hereditary defects, mental and physical; and in certain acquired psychoses. Relative indications are recognized in multiparity, repeat cesarean section, or extensive perineal and lower extremity varicosities. Social factors are occasionally valid reason for sexual sterilization. Economic conditions never are.

The most frequently stated reason for sterilization is multiparity. Multiparity is a relative indication, not an absolute one. By strict definition it is the condition attained when a woman has borne and delivered five living children. Grand multiparity is the condition attained when she has produced ten living children. Regardless of the standard definition, multiparity has become many things to many people. Quite often a woman with three children from three pregnancies is said to have achieved multiparity. And too often one with only two children from two pregnancies is decorated with the laurel of multiparity. But the pure medical definition remains, and it is too often at complete odds with the situation to which it is applied.

A more workable approach to the definition of multiparity is to consider the age of the patient, the frequency of deliveries, and her general physical condition. A woman of 40 years bearing her third child while the older of her two living offspring is less than four years of age should not be criticized too severely if she requests puerperal sterilization. A woman of 25 years bearing her fifth pregnancy while her oldest child is scarcely five years of age should be given benevolent attention when she asks for surgical elimination of her fecundity; and, by virtue of the original definition, she has already arrived at multiparity anyway.

Granted, these are extremes, and do not constitute the usual run of patients requesting sexual sterilization. So since the definition of multiparity has been stretched in all directions, the indications for any given sterilization should be assayed with due consideration of the other basic elements.

Sexual sterilization with repeat cesarean section is a relatively relative indication, if the definition may be so literately qualified. It is a generally accepted fact that the average woman should not have more than three cesarean sections unless she or her family insists upon a greater number. So it is quite ethical as well as considerate for the physician to explain to the patient ready for the third cesarean section that the cesarean operation is a major operation carrying with it the risks and surgical shock of any other major abdominal procedure; hence it is not sensible to multiply the number beyond three unless she and her family accept fully the responsibility for later complications related to repeated laparotomy. If the patient having cesarean sections feels that two rather than three are sufficient, her wishes should be respected and she should be sterilized at her request. After all, she is the one being operated upon. Hers is the abdomen being incised, and hers is the burden of recuperation; so if she thinks two cesarean sections are enough, her physician is obligated to do what should be done to insure that two are all she will have.

Sexual sterilization of hereditary defectives, congenital or habitual criminals, nymphomaniacs, and incorrigibles of other varieties is strictly covered by law, although that law varies in different states and communities[3]. There are no federal statutes regarding it.

Hereditary defectives who can transmit their defects to their offspring can be sterilized on authorization of the courts, their guardians, their physician or the institution where they are kept. In many states sterilization for such individuals in mandatory[3]. Congenital and habitual criminals, as well as other incorrigibles, are mandatorily sterilized in some states, and ignored in others. They should be handled as hereditary defectives, however, from the point of view of pure logic. In enlightened communities this is true; hence, they are sterilized before being released from an institution and turned loose upon society at large.

Nymphomaniacs are variously handled, depending upon their community[3]. Some states decree sexual sterilization; others ignore the subject. In Europe, on the other hand, and especially in the Scandinavian countries, they are recognized for what they are, namely sex psychopaths, and are automatically sterilized when they become public charges[4].

### Restrictions

Sexual sterilization has its legal aspects also. It is surrounded by a maze of laws, rules and regulations that can be used in court. Depriving a woman of the power of reproduction is depriving her of one of her basic property rights. The

[3] Boyden, M. G.: Summary of the Sterilization Laws of 29 States and Puerto Rico, Birthright, Inc., Princeton, 1940.

[4] von Hofsten, N.: Sterilization in Sweden, J. of Heredity 40:243 (Sept.) 1949. Tappan, P. W.: Treatment of the Sex Offender in Denmark, Am. J. Psychiat. 108:241 (Oct.) 1951.

Anglo-American system of statutory law is based on the recognition of fundamental property rights suggested in common law. One of these rights is that of the power to reproduce, assuming nature provided it in the first place. So no patient should be sterilized without her written and witnessed authorization. If she is a married woman, she is in turn the property of her husband, according to the statutory law already alluded to; hence her husband's written and witnessed consent is also required. If he refuses such permission, the sterilization cannot be legally done, even in the presence of otherwise absolute medical indications for it.

A woman separated from but not legally divorced from her husband cannot be legally sterilized without the consent of her lawful husband. If she is legally divorced, and there are adequate medical indications for it, it can be done on her authorization alone.

No physician should sterilize a patient without written consultation to that effect by another qualified and duly licensed physician. If he does, he is guilty of malpractice and open to suit.

It should be borne in mind, then, that whenever tubal sterilization is the primary or even the incidental object of a surgical procedure, adequate written and witnessed authorization and recognized written consultation should be obtained beforehand.

### Who Should be Sterilized?

In rendering any married couple incapable of further reproduction, it should be remembered that the proper partner of the union should be sterilized. If the man should no longer propagate, he, and he alone, should be sterilized. If the woman should no longer reproduce, she, and she alone, should be sterilized. There is very little therapeutic benefit derived from placing a plaster cast on the normal right leg of a fracture victim when his left leg is the one that is broken. Similarly, there is little logic in sterilizing a husband when the wife is the one who should be infertile. And we as practitioners of medicine should not be swayed by the howls of injured innocence from many married couples who feel a young husband should be sterilized to prevent further pregnancies in a still younger wife, simply because she finds the business of child-bearing tedious, and vasectomy is reputed to be done so easily. We are obliged to point out to them instead that human nature remains what it has always been; that there are millions of virile, unvasectomized young men yet in the world, any one of whom can impregnate her quite as effectively as her present husband now does.

So, to repeat, and emphasize, the only individual who should be sterilized is the one who should not reproduce; otherwise the inevitable will occur and a pregnancy appear in the woman with the vasectomized husband, a husband who had been rendered thus sterile so his marital partner would not again bear the burden of gestation.

TABLE 1.—*Sterilization Statistics, Kapiolani Hospital, 18 cases.*

| AGE | GRAVIDA | PARA | TYPE | INDICATIONS |
|---|---|---|---|---|
| 26 | 7 | 7 | Puerperal | Multiparity; hemorrhoids; varicosities |
| 35 | 7 | 6 | Puerperal | Multiparity |
| 41 | 6 | 6 | Puerperal | Multiparity; pre-eclampsia; renal damage |
| 37 | 6 | 6 | Puerperal | Multiparity; economic reasons |
| 46 | 8 | 8 | Puerperal | Diabetes mellitus; persistent hypertension |
| 27 | 2 | 2 | Concomitant | Repeat cesarean section |
| 37 | 8 | 8 | Puerperal | Multiparity |
| 28 | 4 | 3 | Concomitant | Therapeutic curettement for rheumatic heart disease |
| 31 | 5 | 4 | Puerperal | Voluntary |
| 43 | 11 | 8 | Puerperal | Multiparity |
| 34 | 3 | 3 | Concomitant | Repeat cesarean section |
| 40 | 4 | 3 | Concomitant | Cesarean section for hypertensive cardiovascular disease |
| 27 | 4 | 3 | Puerperal | Multiparity; thin, tired, anemic; (appendectomy also done) |
| 32 | 5 | 5 | Puerperal | Multiparity; (incisional herniorrhaphy also done) |
| 30 | 3 | 2 | Concomitant | Repeat cesarean section |
| 34 | 12 | 11 | Puerperal | Multiparity; varicosities |
| 27 | 2 | 1 | Concomitant | Repeat cesarean section |
| 27 | 3 | 2 | Puerperal | Severe bilateral varicosities |

### Effectiveness

Tubal sterilization, regardless of the method employed, is not 100% effective[5]. Simple ligation is followed by up to 25% return of fertility. Tubal resection is attended by 2% failures. Cornual resection is 99% reliable. Total salpingectomy is occasionally followed by abdominal pregnancy. Besides that, salpingectomy, whether partial or complete, carries the risk of interference with ovarian blood supply, and is attended by up to 5% incidence of ovarian cysts within 5 years.

So, to choose the method that works best with the least surgical trauma and postoperative complication, tubal resection is to be preferred.

In an earlier edition of a standard obstetrical text book is a description of a so-called *"temporary"* sterilization[6]. Many patients have the impression that they can be sterilized for two, or five, or however many years they choose; then they automatically become fertile. The text book is responsible for this false idea. The temporary sterilization outlined is simply a tubal resection done without tying off the free ends. They are buried in the leaves of the broad ligament so that they can be anastomosed at a later operation with-

[5] Cooke, W. R.: Essentials of Gynecology, J. B. Lippincott Co., Philadelphia, 1943. Bonney, V.: Textbook of Gynecological Surgery, Paul B. Hoeber, Inc., New York, 1948. Dickinson and Lee.[1]

[6] Stander, H. J.: (Williams) Textbook of Obstetrics, D. Appleton-Century Co., Inc., New York, 1936.

out requiring the excision of the quantity of scar tissue usually encountered when those ends have been previously ligated. So the only temporary feature about the procedure is how long the patient wishes to wait before submitting to salpingoplasty or tubal implantation. And it is well known that these measures at best are only up to 25% effective in reestablishing fertility[7]. The idea of temporary sterilization should be removed from the public mind.

### Sterilizations at Kapiolani Hospital

The statistics of the sexual sterilizations done in this hospital for six months of this year (1953) have been perused for pertinent details. There have been 70 such operations. I have arbitrarily selected the first three cases listed for each month, and the following facts appeared: of the 18 cases, 12 were puerperal or postpartum sterilizations; 6 were concomitant, 5 of them with repeat cesarean section, 1 with a first cesarean section, and 1 with therapeutic abortion. Multiparity was given as the indication in 9 cases, or 50% of those reviewed. Varicosities of legs and vulva were named in 4 patients, although in only 1 were they the sole indication noted. A scattering of other complications was present, but multiparity, as expected, dominated the group.

Incidentally, there were 1,755 live births recorded in this institution in those same six months.

Table 1 gives an abbreviated review of the cases analyzed. The indications listed are those noted by the operating surgeon on the consultation sheet of the hospital record, and I have copied them directly. The other data are abstracted only.

### Summary

The generally accepted surgical procedures employed at this institution for tubal sterilization have been mentioned. Indications, legal aspects, and general comments have been added. A limited statistical study of the tubal sterilizations done in this hospital for six months of 1953 has been outlined.

### Conclusion

There is a place in the practice of medicine for sexual sterilization in women. The procedures are now more or less standardized in this hospital. They should be applied only when adequately indicated. The legal safeguards should be kept in mind. Only the person who should *not* reproduce should be sterilized.

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[7] Greenhill, J. P.: Evaluation of Salpingostomy and Tubal Implantation for Treatment of Sterility, Am. J. Obst. & Gynec. 33:39 (Jan.) 1937. D'Ingianni, V. D. and Fontenelle, I. L.: Implantation of the Salpinx Employing a Cannula, South. M. J. 44:1139 (Dec.) 1951.

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For further information regarding registration, reservations, etc., write to F. J. Pinkerton, M.D., Director General, Pan-Pacific Surgical Association, Suite 7, Young Building, Honolulu, Hawaii.

# APPENDICITIS EPIPLOICA

## Report of Six Cases

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THE first description of disease of the appendices epiploicae is credited to Vesalius. Since then, several authors have described appendicitis epiploica, most adding a few cases to the literature.



DR. RICHERT

Fieber and Forman[1] recently reported 105 cases from the literature and added 3 cases of their own. Their article gives a clear summary of the history, anatomy, pathology and incidence of this condition.

I wish to add 2 cases of my own (1 & 2) and 4 others from records of The Queen's Hospital, Honolulu. These 4 cases were the only proven ones listed on the record of The Queen's Hospital during the past ten years among approximately 120,000 admissions. St. Francis Hospital, Honolulu, has only the 1 case, here presented (case 2), on its records back to 1945, with an approximate figure of 57,000 admissions.

### Case Reports

CASE 1.—J. T., age 24, was a well developed, muscular, small Filipino laborer, admitted February 10, 1946, to The Queen's Hospital. He gave no history of chronic constipation or frequent gastro-intestinal upsets. On first day of illness, he had awakened with a mild pain in the right lower quadrant, which gradually increased throughout the morning. There was associated nausea, but no vomiting. He passed three rather loose stools in the twelve hours preceding medical attention. There was slight to moderate guarding in the right lower quadrant of the abdomen, and referred and rebound pain were moderate. On rectal examination there was acute tenderness in the cecal area. Temperature 98.8 F.; white cells 8,800, polys 65%, lymphocytes 50%, eosinophiles 5%; urine normal. In spite of the low white count, it was decided that this man had an acute belly and should be explored. The preoperative diagnosis was acute vermiform appendicitis.

He was admitted to The Queen's Hospital, and under general anesthesia the belly was opened through McBurney's incision. The appendix presented itself in its normal position and showed no pathological change. The cecum was then brought into the wound, and 4 cm. above the iliocecal valve, on the lateral aspect of the colon, was found an acutely inflamed, infarcted pregangrenous appendix epiploica, measuring 1 x 1.5 cm., which came free from the bowel when it was grasped lightly with thumb forceps. Its former attachment to the gut was explored carefully and no diverticulum could be found. There was no bleeding and no suture or ligature was used on its former point of attachment. No other epiploic fat tabs in the vicinity appeared to be involved. A prophylactic removal of the vermiform appendix was done. The belly was closed with fine cotton without drainage. P.O. course was afebrile and uneventful. Patient was last seen May 10, 1953, seven years after surgery, and has had no recurrences. Final diagnosis was "Early gangrenous appendicitis epiploica due to torsion of pedicle."

CASE 2.—A. G. was a well developed, muscular Filipino laborer, 28 years old, admitted to St. Francis Hospital May 3, 1953. He complained of having pains in lower belly, mostly on the right, during the previous eighteen hours. He had had slight nausea off and on for the preceding three weeks, but no vomiting or diarrhea. During the past six hours, pain had been restricted to the right lower quadrant and right flank, up into the right costovertebral angle. There had been no urgency, frequency or dysuria. Urine was negative; blood count showed a white count of 12,200, with 62% polys, 35% lymphocytes, and 2% eosinophiles.

Physical examination was negative except for the abdomen. There was moderately severe pain and tenderness in the r.l.q. with guarding up into the right flank. There was pain, but no tenderness, in the right costovertebral angle. Rebound pain, tenderness and referred pain were maximum at a point midway between the umbilicus and the right iliac crest. No rectal tenderness was elicited. Admission diagnosis was "acute vermiform appendicitis."

Under spinal anesthesia the belly was opened by McBurney's incision. The cecum did not present itself, but in its place was the sigmoid. This was traced down over the pelvic brim and upward and was a true right-sided sigmoid. In tracing the sigmoid upward, an acutely inflamed, infarcted appendix epiploica came into view. It was on the antero-lateral sigmoid just at the level of the iliac crest. Three other appendices epiploicae in this area were similarly involved, but to a lesser degree. They were slightly engorged and edematous and had from three to five turns in their pedicles. All affected appendices were removed and their bases ligated.

In searching downward for other affected fat tabs, a free-floating wax-like ovoid mass 2½ x 1½ cm. was found. This undoubtedly was the remains of a previously sloughed appendix epiploica with resultant encapsulation of the fat (most of the appendices in this area were longer than normal).

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Department of Surgery, Fronk Clinic.
[1] Fieber, S. S., and Forman, J.: Appendices Epiploicae: Clinical and Pathological Considerations. Report of Three Cases and Statistical Analysis on One Hundred Five Cases, A.M.A. Arch. Surg. 66:329 (Mar.) 1953.

The belly was closed with fine cotton. The post-operative course was uneventful, and he was discharged from the hospital on the fourth day. Final diagnosis: 1. Appendicitis epiploica due to torsion of pedicle; 2. Right-sided sigmoid. Pathological diagnosis: 1. Infarction of appendices epiploicae; 2. Incapsulated fat.

CASE 3.—M. H., a 43-year-old Hawaiian woman, was admitted to The Queen's Hospital September 4, 1950, from Kalaupapa Settlement. She had had no previous surgery. There was a history of epigastric pain during the preceding fifteen hours, gradually shifting into the right lower quadrant, with nausea and vomiting. Temperature on admission 100°F., white count 12,100, polys 72%, lymphocytes 27%; blood pressure 200/110. The abdomen was soft. There was tenderness in the "appendiceal area." No guarding was present. The preoperative diagnosis was "acute vermiform appendicitis." Under general anesthesia, a McBurney's incision was made. The appendix was normal, but considerable straw-colored fluid was present. A small gangrenous appendix epiploica was removed from the cecum. The vermiform appendix was also removed. The belly was closed tightly.

Final diagnosis was "appendicitis epiploica" and prophylactic appendectomy. The post-operative course was uneventful and the patient was discharged back to the leprosy settlement on the tenth post-operative day.

CASE 4.—M. R., a 64-year-old Portuguese man, was admitted to The Queen's Hospital October 2, 1950. No previous surgery or symptoms referable to "appendix" were recorded. In the course of a cholecystectomy and exploration of common duct for stones, the surgeon noted and removed a "strangulated appendix epiploica" in the region of the cecum. This was confirmed by pathological report.

CASE 5.—S. M., age 31, a Caucasian woman, was admitted to The Queen's Hospital July 26, 1951. There had been two previous pelvic laparotomies, but no history referable to "appendicitis" since previous removal of vermiform appendix. In the course of a repeat uterine suspension there was noted and removed by the surgeon "an acutely inflamed cecal epiploic appendage." This was confirmed in the pathological report.

CASE 6.—B. M. O., a 25-year-old Japanese woman, was admitted to The Queen's Hospital July 17, 1952. On the evening prior to admission, the patient had noted diffuse pain in the abdomen, more in the epigastric region. In the past six hours, the pain had shifted into the right lower quadrant and was of a dull, constant character. There was anorexia, but no vomiting. She was able to eat some breakfast. Previous history was noncontributory.

Physical examination was negative except for the abdomen, where point tenderness was found in the right lower quadrant, with rebound tenderness and tenderness over the mid-portion of the abdomen. There was no guarding or muscular rigidity.

Admitted for surgical observation for appendicitis. White count was 10,900, with 73% polys and 7% eosinophiles. After thirty hours of observation, pain and tenderness in the right lower quadrant remained. There was a fall in the white count to 9,600 with 49% polys; however, exploratory laparotomy was advised and performed.

Under spinal anesthesia a paramedian incision was made, and on entering the peritoneal cavity, a moderate amount of free bloody fluid was noted. Pelvic organs appeared normal. There was found free in the peritoneal cavity a hemorrhagic mass thought to be old blood clot. It was removed and included in the specimen submitted to the laboratory. The vermiform appendix was not inflamed. Prophylactic appendectomy was done. Pathological report: 1. Lymphoid hyperplasia of appendix; 2. Detached appendix epiploica with necrosis.

## Summary

A report of 6 cases of appendicitis epiploica has been made, 2 from my personal experience and 4 from the records of the Queen's Hospital. Four cases were primary appendicitis epiploica and 2 were incidental findings to other surgical procedures.

Case 2 is, I believe, most instructive, for in one case it gives a complete picture of the mechanism, acute phase, and final fate of appendicitis epiploica.

This is just one more condition to rule out when contemplating surgical removal of the vermiform appendix, or to check on when the appendix is pale and apologetic.

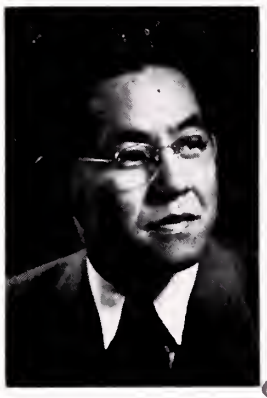
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# CONGENITAL TUBERCULOSIS

## Report of Two Cases

PETER KIM, M.D.,* Kealia, Kauai

INFECTION of the fetus from tubercle bacilli may not be as rare as is generally supposed. During the past fifteen years numerous articles and case reports on the subject have been written.



DR. KIM

Congenital tuberculosis is usually considered to be fatal. It would be interesting to know how the infant mortality rate due to this disease will be affected by chemotherapy.

Congenital tuberculosis may be defined as an infection acquired in utero or during passage through the birth canal by aspiration or ingestion of infected material.

To make the diagnosis there must be proof that the infection was acquired before birth. The diagnostic criteria generally accepted are: 1) the mother must have an active tuberculous focus or foci, 2) the infant should have been immediately isolated from the mother and placed in an environment free from any possible chance of postnatal infection, 3) the infant must be proven to have tuberculosis, and 4) the nature and location of the lesion, the clinical history of the disease and other laboratory tests should be compatible with tuberculous infection acquired before birth.

The following cases meet the diagnostic criteria of congenital tuberculosis.

### Report of Cases

CASE 1.—A premature, part-Hawaiian female infant was delivered spontaneously on February 20, 1952, at Waimea Hospital, Kauai. The placenta was grossly normal in appearance. The infant weighed 4 pounds 13 ounces and measured 17½ inches in length.

The infant was placed immediately in an incubator. The general appearance was noted to be normal. The rectal temperature was 98° F. She was started on formula.

She was taken out of the incubator on the seventh hospital day. The weight was 4 pounds 7 ounces. On the eleventh day the nurses noted that the baby was taking nourishment very poorly and the rectal temperature was 99° F. On the fourteenth hospital day the temperature rose to 102° F. rectally. The temperature chart thereafter showed a spiking type of curve.

A white blood count taken on the fourteenth day was 24,650 with 40% polymorphonuclear cells, 33% lymphocytes, 3% monocytes, 1% basophiles, and 17% stabs, 3 pro-lymphocytes and 3 metamyelocytes. Two days later it was essentially the same. The hemoglobin was 16 grams.

On the fifteenth hospital day the infant was transferred to the isolation room. Physical examination at this time revealed an infant having rapid, semi-labored respiration. A chest film (Fig. 1, left) taken on this day revealed scattered nodular densities throughout both lung fields. A diagnosis of pneumonitis was made and penicillin therapy was started.

The infant continued to do poorly. Terramycin was added on the twentieth day. On the thirtieth hospital day, rales and dullness to percussion were noted on physical examination. Cyanosis was now evident in the extremities and oxygen was given. A non-productive cough was also noted. A chest film (Fig. 1, right) taken on this day showed extensive confluent nodular densities throughout both lung fields characteristic of a miliary involvement.

The infant's condition deteriorated rapidly and on March 29, 1952, 38 days after birth, the infant expired. Autopsy one hour after death disclosed acute tuberculous pneumonia in both lungs with abundant bacilli.

The mother's chest x-ray showed bilateral pulmonary tuberculosis. Tracheal lavage was positive for acid-fast bacilli on culture.

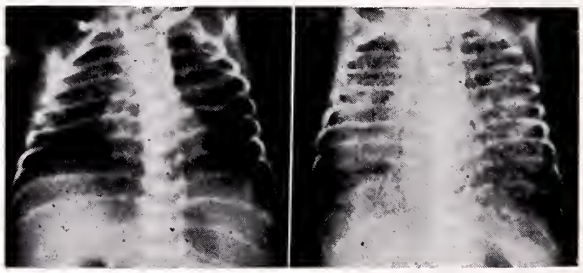


Fig. 1. (Case 1). On left, scattered nodular densities throughout both lung fields on fifteenth hospital day. On right, extensive miliary involvement fifteen days later.

#### Further Studies

Subsequent examination of the mother revealed tuberculous involvement of the spine. The first and second lumbar vertebrae were almost totally destroyed and the third, fourth and fifth vertebrae had extensive involvement in the anterior portion. There was a tender, reddened area of swelling in the right flank region which was probably an extension of the cold abscess.

Pelvic examination did not show any suspicious tu-

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berculous lesion. Culture of the cervical discharge was negative.

Past history revealed that the two oldest children had been in Leahi Hospital for tuberculosis.

CASE 2.—M. C. was a female infant admitted to Leahi Hospital at the age of five weeks.

The infant's mother had been hospitalized in a general hospital in 1949 for two months. She was discharged as "sarcoidosis of lungs with pleural effusion bilaterally." She was given streptomycin (99 grams) and PAS (amount not known). In January, 1952, she was found to have a minimal left upper lobe lesion, which was said to have cleared by March. She was treated by a private physician with PAS.

The infant was born April 5, 1953. The mother, gravida I, was in labor 32 hours. No instruments were used. No gross abnormality of the placenta was noted; it was not sectioned. The infant breathed spontaneously. The infant was not put to breast. For two weeks she seemed well. During her third week the infant refused her feedings, developed a cough and diarrhea, and was found to be running an elevated temperature (101 to 102° F.). She was taken to a doctor when she was three weeks old. Penicillin and Terramycin were given, but her condition became worse. On May 13, the white count was 22,000 with 90% polys. Spinal fluid: 12 lymphs; protein 44; sugar 43; chlorides 717.

The patient was admitted to Leahi Hospital May 14, 1953, at the age of five weeks. She appeared acutely ill. The head was held in hyperextension, but there was no nuchal rigidity. She became cyanotic on the slightest exertion. Lungs were full of rales. Gastric aspiration was positive for M. tuberculosis on smear and culture. Spinal fluid May 20, 1953: cell count 39; sugar 70; chlorides 725; culture negative.

She was given penicillin 100,000 units daily; INH 25 mg. daily; streptomycin 0.25 gram until May 23, when dosage was reduced to 0.1 gram; PAS 0.5 gram May 15 to May 21. She was tube fed and maintained in an oxygen tent. Course was steadily downhill. On June 12, 1953 she expired.

At autopsy there were many large and small caseous nodules extensively distributed throughout all lobes of the lungs. There was extensive involvement of the mediastinal lymph nodes. The spleen showed innumerable minute tubercles throughout. The liver also contained many miliary tubercles.

The mother was operated upon June 5, 1953 for a pelvic mass. Omental biopsy disclosed tuberculosis. X-rays and gastric washings over a four month period have shown no evidence of pulmonary tuberculosis.

## Comments

It is an accepted medical fact that tubercle bacilli can pass through the placenta and may infect the fetus. An interesting question may arise as to why more babies are not born with tuberculosis. Vorwald[1] has experimentally demonstrated that there is a consistent difference in the response of the guinea pig fetus and that of the adult guinea pig to tuberculous infection. When the tubercle bacilli were inoculated into the fetal body in utero, the fetal tissues consistently showed marked resistance by inhibiting the growth of the bacilli and preventing the development of progressive tuberculous infection. He has suggested that one possible factor of increased native resistance of the fetus may be the relative oxygen deficiency present in fetal tissues.

The influence of available oxygen supply in the development of tuberculous infection was shown in the experiments of Rich and Follis[2]. They demonstrated that the progress of tuberculous infection can be markedly inhibited by reducing the oxygen supply to the tissues, which indicated that the amount of available oxygen in different tissues may play a significant role in determining the degree to which they are involved by the disease. In this connection, the relatively high oxygen tension in the lung tissues after birth may account for the greater frequency of lung involvement in congenital tuberculosis..[3]

Since the lungs were the only organs grossly involved in the first case, one might justifiably question whether the infection was acquired by way of the blood stream or by inhalation or ingestion of infected material. The relatively short period before symptoms became evident, and the fact that the lesion could be demonstrated by x-ray on the fifteenth day, suggests that infection was congenital. To establish the mode of infection from the nature of pulmonary lesion alone would be difficult.[4] However, the x-ray appearance of the lesion was characteristic of a hematogenous type of spread.

The second case was not isolated immediately after birth. However, the clinical history of the disease in the infant and the type of tuberculous involvement in the mother leaves no doubt as to the congenital nature of her condition. Chemotherapy was not effective in this instance, probably because the disease had progressed too far.

## Summary

Two fatal cases of congenital tuberculosis are presented.

It would be interesting to see how chemotherapy will affect the infant mortality rate due to this disease.

## Acknowledgment

The clinical history of Case 1 was made available through the courtesy of Dr. Marvin Brennecke. Clinical data relating to Case 2 were supplied through the courtesy of Dr. Brooke Jamieson of Leahi Hospital, Honolulu.

[1] Vorwald, A. J.: Experimental Tuberculous Infection in the Guinea Pig Foetus Compared with That in the Adult, Am. Rev. Tuberc. 35:260 (Feb.) 1937.

[2] Rich, A. R., and Follis, R. H., Jr.: The Effect of Low Oxygen Tension upon the Development of Experimental Tuberculosis, Bull. Johns Hopkins Hosp. 71:345 (Dec.) 1942.

[3] Siegal, Morris: Congenital Tuberculosis, Am. Rev. Tuberc. 29:297 (Mar.) 1934.

[4] Rich, A. R.: The Pathogenesis of Tuberculosis, ed. 2, Springfield, Charles C. Thomas, 1951, p. 75.



# *The President's Page*

The Audio-Digest Foundation, a non-profit subsidiary of the California Medical Association, has prepared 52 lectures by leading authorities for release via tape recordings and film strips. It is planned to secure some of these lectures for circulation to component societies and various specialty sections.

Today's physician is actually swamped in literature. With the voluminous articles appearing in the many journals that accumulate in untidy stacks in his office and with so little time at his disposal to digest the material, the physician is most fortunate if he is able to read only the title and the conclusions of each article. The audio-visual series offers each week a one-hour lecture summarizing the current medical literature (approximately 600 journals), a concise digest of those stacks of journals in your office. It is nice to have somebody help you with your reading. I can think of no better way to keep abreast of the times than by audio-visual graduate education. Experts in the various fields of medicine present the material in a compact, easy-to-understand manner.

It is not outside the realm of possibility to expect that some day even television may be used in Hawaii for graduate medical education. One of my most profitable experiences at the last AMA convention included attendance, along with hundreds of other physicians, at television demonstrations. The TV shows were in color too, and we saw the details of delicate surgery of the heart through the surgeon's eyes. The TV cameras followed the scalpel and every bit of the pathological specimen was visible as the surgeon described the operative procedure. No surgical amphitheater could have provided such visibility for so vast an audience. The hundreds of viewers at the TV screen were able to see more than even the first assistant at the operating table. This is unquestionably an excellent medium for teaching.

When the teachers in the large medical centers of the mainland deliver their graduate lectures, we in Hawaii will be privilegd to hear them and to see their data, pictures, and charts through the medium of audio-visual programs of today. And who knows? Television may some day be a routine medium for disseminating medical information locally.

Aloha,

R. K. Chungstoon, M.D.

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## [EDITORIALS]

### WELCOME TO PEDIATRICIANS AND "EENT" MEN!

**Hawaii's doctors extend a warm Aloha to the members of the American Academy of Pediatrics who meet in Honolulu on April 13, and to the Pacific Coast Oto-Ophthalmological Society, which will hold its annual meeting in Honolulu from April 25 through 28. We are confident their gatherings will be so well-attended, so informative, so much fun, and so generally successful that they will be held here again, and that other nation-wide medical organizations will follow their example.**

### SAFETY VACCINE FOR PARENTS

In Hawaii, as on the mainland, accidents are the leading cause of death among children from 1 to 9 years of age and are the second cause of death up to 24 years of age. In the U.S.A. accidents kill over 11,000 children each year. Many thousands more are seriously injured or crippled for life. Only during the first year of life are accidents relatively infrequent.

At the present time many agencies in Honolulu are active in special fields of accident prevention. The Police Department, public schools, industry, Health Department, Red Cross, Traffic Safety Commission and the medical societies are all doing some preventive work, but there is still much to be done.

The individual physician should assume some responsibility for safety education, just as he does for immunization against certain diseases. The more specific this "safety vaccine" is, the better will be the results: effective safety education must be focused on specific problems in specific age groups. The family physician or pediatrician is therefore in a strategic position to help in this work.

Education must be geared to the maturity of the child, since the most common types of accidents are associated with the child's growth and development. For example, one would not expect a 6-year-old to swallow a safety pin or a 2-year-old to fall out of a tree.

In order then to prevent accidents associated with the maturity of the child, one must be able to anticipate how, when, and in what manner the child is likely to get into trouble. Parents must be instructed when to restrict and protect, and also when to "let go", and permit the child to learn from his own experiences. Sooner or later he must discover for himself that flames are hot, but these experiments must be so controlled that he does not harm himself or others. Mild, consistent, and logical discipline, therefore, must be combined with "know how" and sincere affection, in order to encourage physical and emotional security in the child. The "accident prone" child, of course, is a special problem needing individual study.

Why not devote a few minutes, while giving each yearly childhood checkup, or while treating an accident victim, to give the parents a few suggestions on accident prevention specifically appli-

cable to their problems? Literature on this subject is available at the Territorial Board of Health and the Honolulu Pediatric Society. Frequent small doses of this type of "safety vaccine" are more effective than an occasional large dose.

W. A. MYERS, M.D.

## REPORT OF THE JOINT COMMITTEE ON CHEST X-RAY

Substantial agreement on the problems of routine chest x-rays in hospitals and mass chest x-ray survey programs has been achieved by the American College of Chest Physicians and the American College of Radiology, and is expressed in a report of the two Colleges' Joint Committee on Chest X-Ray, issued February 4, 1953, published last May in *Diseases of the Chest*,[1] and recently circulated to all state medical journals.

The Colleges are agreed that each physician "should be encouraged to have a chest x-ray of all his patients; that every patient admitted to a hospital . . . should have a routine chest x-ray; and that the follow-up for all suspected lesions . . . should be organized very carefully . . ." One can imagine that the first of these aims might require rather more encouragement than the two Colleges between them could command. The second and third seem more reasonable.

The Joint Committee recommends that the hospital radiologist "should be compensated just as [*sic*] any other physicians practicing his profession." One would presume (though it is not so stated) that "just as" means on a fee-for-service basis, which seems to us distinctly unrealistic and unreasonable.

Double reading of films is not unreservedly recommended, and agreement has not been reached on qualifications of persons reading the films. Reporting of results is said to be a local or regional problem.

Such further details as x-raying fully clothed persons (this is all right), protecting personnel around photofluorographic units (they may receive with safety up to 100 milliroentgens per week), reporting "tuberculosis" (this is a clinical diagnosis and should not be made from survey films), and others, are also covered in the report. No mention is made of the possible usefulness of the tuberculin test in relation to investigations for pulmonary tuberculosis.

The report is of particular interest in view of the joint mass chest x-ray survey project of the Hawaii Cancer Society and the Oahu Tuberculosis and Health Association, scheduled for May, 1954, in the semi-rural Waipahu and urban Kalihi areas, with the cooperation of the Bureau of Tuberculosis of the Territorial Department of Health.

[1] Volume 23, page 589 (May) 1953.

## USE OUR TUMOR CLINICS!

Competent Tumor Boards of representative specialists, serving all patients without charge, are available at both St. Francis and The Queen's Hospitals. St. Francis Tumor Clinic meets at 12:30 P.M. on the second Tuesday of each month, and Queen's Tumor Clinic at 4:15 P.M. on the first and third Monday of each month. Patients are seen by appointment on referral from any physician.

It is not so long ago that a patient was found to have a suspicious lesion in a survey x-ray fluorogram. Confirmation in a 14 x 17 film was obtained within a week or so. Consultation through a local hospital (not through a tumor clinic) required about another month, and it was nearly an additional month before the patient reached one of the Tumor Clinics, where it was felt that the lesion was not inoperable.

This two months' delay, or near it, was not actually the fault of any one person; it was the result of a combination and succession of circumstances. But it was unnecessary, and it could have been avoided had the patient been referred to a Tumor Clinic by his physician in the first place.

Please take notice that this valuable consulting service is available, and make use of it promptly when the occasion arises.

## HAWAII DIET MANUAL, 1953

The Hawaii Diet Manual was revised this past year to keep abreast of the newer trends in diet therapy and to include newer methods approved by the American Dietetic Association. Each diet has been planned with its indication for use, the dietary principles, foods allowed, foods to avoid and a sample menu for one day. The major changes in the new revision are:

A tube feeding which meets all dietary requirements is listed. It provides 90 grams of protein, 90 grams of fat and 375 grams of carbohydrate, a total of 2400 calories being furnished.

A Post-operative Gastric Diet was added to meet the new demand. Its main objective is to gradually introduce food to the patient in six small feedings and progress gradually.

A Minimum Residue Diet was added because of increased demand and is used particularly for hemorrhoidectomy, uncontrolled colostomy and prevention of bowel movements.

A Low Sodium Diet (500 milligrams of sodium) was added because of increased demand. It is a very restricted diet, which excludes many locally used foods, such as mono-sodium glutamate (Ajinomoto), highly seasoned soups as miso, oriental soups and

Portuguese soup, all salty foods, smoked, processed and canned meats, and carbonated and soda waters. Recipes for low sodium bread and mayonnaise are included.

In diabetic diets, the new diabetic exchange method for diabetic foods is used. This method was prepared and approved by committees of the American Diabetes Association, The American Dietetic Association in cooperation with Diabetes Branch-Public Health Service, Federal Security Agency, and this is the accepted standard and is being adopted universally.

This publication, like the first one, includes local foods in the diets which can be adapted to the various racial food habits. The diets are presented in a simplified form to be used by physicians, clinics, hospitals and patients.

MRS. SAYAKO OUMAYE
*Chairman, Diet Therapy Section*
*Hawaii Dietetic Association*

## SEVEN AIMS OF THE MEDICAL CURRICULUM

A wise and thoughtful physician—Sir Henry Cohen, Professor of Medicine at the University of Liverpool—reviews, in a recent issue of one of the world's top medical periodicals, *The New England Journal of Medicine,* the balanced medical curriculum.[1]

The star to which he advises hitching the medical school's wagon is defined at the end of the article in the following seven characteristics which he hopes the school can impart to its graduates:

Firstly, he shall have acquired the basic medical knowledge and technics that will prepare him not simply for general practice but also for any specialty so that he retains a general outlook and appreciates the significance of advances in general knowledge for his chosen branch of practice.

Secondly, he shall have developed habits of logical thought and critical judgment of evidence and experience that will prevent his falling a victim to indefensible faiths and seductive fallacies. For him "post hoc" will not be a sufficient therapeutic criterion; correlations will not always be casual; nor will he "to the fascination of a name, surrender judgment, hoodwinked."

Thirdly, he will know where and how to seek help and acquire knowledge both from men and from books. "You cannot learn men from books," said Disraeli; but to study medicine without books is, as Osler wrote, "to sail an uncharted sea."

Fourthly, he will have the urge to continue self-education in the wise and critical spirit of Plato's dictum that "Education is a lifelong business."

Fifthly, he will have acquired a rational approach to medicine and recognized that there are uses as well as limitations to empiricism, that patients are living sentient beings and not simply "cases" and that, in the words of Trousseau, "There are no diseases, only sick people."

Sixthly, he will have been made more fully aware of his obligations and responsibilities as a doctor to the individual and to the community, and will shape his conduct by the ethical and moral principles of his profession.

Seventhly, and lastly, he shall be a cultured and educated gentleman, seeking wisdom through knowledge, cultivating and cherishing his ideals, ready to meet a challenge and grasp an opportunity for service to his fellow men, remembering that he can cure and prevent only occasionally, relieve often but comfort always.

[1] Cohen, H.: The Balanced Curriculum, New England J. Med. 249:871 (Nov. 26) 1953.

These are pretty high standards for a newly graduated physician. How many of us 5, or 10, or 20 years out of school can measure up to them? It might do us good to try.

## PATIENTS ARE *PEOPLE*

A patient is not a "male" or a "female." A patient is a man, or a woman—or a boy or girl.

Many interns fall into the habit of referring to a man or woman under their care as "a twenty-three-year-old Japanese male" or "a forty-year-old white female." This sort of professional pidgin English is motivated largely, at the outset, by a half conscious wish to sound technical and professional. It eventually becomes the habit of a lifetime.

It doesn't sound particularly professional, actually. It sounds lazy, and it sounds regrettably impersonal. "Male" conveys nothing more than the patient's sex. "Man" (or "boy") would convey the age group too, and the genus and species as well (besides being twenty-five per cent shorter). "Mechanic," or "housewife," or "business executive," would convey something human and personal in addition.

It is but a step from *calling* a patient a "male" to *thinking* of him as just a "case," instead of as a complicated human being with an individual personality and individual problems, both of which have a very real bearing on his illness, be it primarily emotional or primarily physical in nature.

"Male" and "female" are useful descriptive adjectives, but vague and inexact substantive nouns. Using them to designate particular human beings is a mark of professional immaturity, an indication of insensitivity to the fact that patients are people.

# This is What's New!

Holdsworth and Hardy, of Sheffield, England, outline the early treatment of **paraplegia from fractured spines,** based on their experiences with 68 cases of thoraco-lumbar fractures. For the spine injury they advise internal fixation if the fracture is unstable. For the cord injury, they found nothing of avail, and *none* of their 68 patients showed improvement of the cord signs. Pennybacker editorializes in the same issue on these important fractures and concludes, "In the absence of manometric block, there is really nothing to be said for operation (i.e., laminectomy), and the patient can be spared a useless procedure." (J. of B. and S. Surg. 35-B:540 [Nov.] 1953.)

**Maggots,** no longer in vogue therapeutically, but still remembered as effective cleaners of necrotic wounds, **secrete collagenase.** This enzyme digests collagen and may explain in part the effectiveness of these creatures. (Ann. Surg. 138: 932 [Dec.] 1953.)

**Cooling patients** before and during **cardiac surgery** has both advantages and disadvantages, according to Bailey and co-workers. They chilled their patients by means of a rubber blanket through which cold brine was circulated. With body temperature around 75° F., they were able to interrupt circulation for 22 minutes and perform a "switch over." A switch over anastomosis merely involves switching transposed great vessels to more normal positions by dividing and anastomosing aorta and pulmonary arteries. After operating on 13 patients with 9 fatalities, they found that hypothermia is most successful in small children with congenital heart disease involving the right side. (J. Thoracic Surg. 27:73 [Jan.] 1954.)

Fang Shih-Shan discourses on Effects of War on the Health of the People—as viewed from Peking. Medical progress is divided into two phases —before or after the "Liberation" of 1949. Before 1949 disease was rampant and no one did much about it. After 1949 everything was better and is still improving. "Our children and students lead now a happy life. Following Chairman Mao Tse-Tung's instruction, 'Health First' . . ." No mention is made of what happens to him who decides "Health Second!" (Chinese Med. J. 71: 321 [Sept.-Oct.] 1953.)

Harte and Chow summarize a symposium on $B_{12}$ at Johns Hopkins. Conley is quoted as having held patients with pernicious anemia in remission for up to two and one-half years by use of 1,000 micrograms of $B_{12}$ orally once a week. No exogenous source of intrinsic factor is required with this large dose. $B_{12}$ tagged with radioactive cobalt is concentrated in the kidneys suggesting this might be the metabolic focal point. (Science 118:582 [Nov. 13] 1953.)

**How long does a leukocyte live?** L. P. White tagged leukocytes in vitro with Atabrine and found that the transfused cells disappeared from the peripheral blood in **an hour** or so. Bierman et. al. in the same laboratory had previously shown that the WBC's are probably removed as they pass through the lungs. (Blood 9:73 [Jan.] 1954.)

They're plying **Norwegian rats** with **alcohol, beer, and wine** at Johns Hopkins. Richter reasoned that since this animal has shared man's dwellings and table food for untold generations, he was the logical choice to share his spirits. The rats had their fluid intake restricted to various alcoholic drinks. The animals automatically reduced their food intake to compensate for the added calories in their drinks. The total caloric intake remained the same as with the controls. Not only did they keep a normal caloric intake, but even after prolonged substitution of an alcohol solution for water, they still preferred water to alcohol and no chronic alcoholics appeared. (Quart. J. Alcohol 14:525 [Dec.] 1953.)

In Montreal, Dörken subjected 68 **medical interns** to a battery of **psychological tests.** The mean I.Q. was 131.10, the dullard in this group being merely "bright normal" with an I.Q. of 115. Based on the Rorschach, however, one-third to one-half were emotionally or intellectually immature. Those interns who later went into psychiatry had a higher tension anxiety level with more original and creative responses. (Canad. Med. Assoc. J. 76:41 [Jan.] 1954.)

FRED I. GILBERT, JR., M.D.

# Perhaps It's Your Nerves

## ON MAKING A PSYCHIATRIC REFERRAL

Robert A. Kimmich, M.D.*

Referring a patient for specialty help of any type should be one of the most carefully and sensitively performed procedures in medicine. Such referral means that he must interrupt an already established relationship with his regular doctor; he must be prepared to meet an additional expense; he must face the realization that his difficulties are serious enough to warrant the attention of a specialist in the field.

Many physicians have said that one of their most difficult tasks is that of telling a patient he needs psychiatric help. This is understandable, since, in the minds of many lay and medical people, there is a stigma regarding emotional illness. It is natural to fear and resent things which are unfamiliar. It is of interest that the greatest resistance to making the referral is usually with the physician, and that most patients react with gratitude to a sensitive and timely psychiatric referral. Perhaps some discussion and suggestions from the viewpoint of the psychiatrist (who must receive the patient) may be of value in making this process one of greater ease and mutual satisfaction.

One must clearly understand that the first step in the treatment of emotional illness depends upon the ideas, the attitudes and feelings of the patient as they exist when he makes his original contact with us. These attitudes are significantly shaped by the referring physician. Speaking generally, we know that if the patient realizes he has some emotional difficulties, wants these corrected, seeks psychiatric help, and has a general idea of his part in this helping process, a satisfactory therapeutic result will occur more quickly and easily than if these things are not true. In fact, misconceived initial attitudes may lead to refusing help, breaking off in the midst of treatment, or a greatly prolonged or unsatisfactory course of treatment. This means that the attitude-forming source or referring agency is the very beginning of the psychiatric helping process. Proper interpretation of need, and astute referral technique, will help immeasurably in reducing anxiety and developing a positive attitude in the patient and in the acceptance of the new physician and his treatment. For these reasons we must scrutinize our actual technique of making referrals and attempt to make the process of referring a person for psychiatric help operate in an optimal way.

After the doctor has established in his own mind the advisability of sending a patient to a psychiatrist** he must convince the patient that his symptoms have an emotional cause. This must be done by calm presentation of positive, understandable findings. He must not use the old cliché, "I cannot find anything physically wrong, therefore it must be in your mind." This is an unconvincing and negative approach. Instead, the patient should be told what he *does* have without going into unnecessary or anxiety increasing detail. This explanation must be done in words and language that the patient will understand without the use of technical terms which will only confuse him. For example: "As a result of my examinations and our discussion of your history and symptoms I find that your difficulty is one which is largely rooted in emotional problems or worries. Your heart palpitation, trouble with breathing, attacks of sweating, insomnia and irritability are truly physical and you do not imagine them, but they are brought on by some emotional tension. Etc." Then, "I am glad to tell you that you do not have the serious heart trouble you suspected. This was clearly proven by my examinations."

At this point the physician should pause to give the patient a chance to react to this new idea. He will often object, or deny the presence of worries and problems. His comments should be accepted as sincere, but it should be pointed out to him that we are often not consciously aware of our most pressing problems.

He should not be told the exact psychological basis for his trouble (even if this is known) or given a psychiatric diagnosis. That should be left for the psychiatrist. Apologies or too much protest should also be avoided, because this makes the patient suspicious. The patient feels more secure knowing that his physician is clear in his own mind and has no misgivings about the referral.

After the doctor has had a chance to discuss the concept that the symptoms may be psychologically based, then a recommendation as to proper handling should be made. It may be explained that best results are obtained by physicians especially trained in the study and treatment of nervous or emotional disorders (or some such term—avoid the word "mental"), and that for his benefit you would like the opinion and recommendations or treatment of such a specialist: a psychiatrist. The doctor then suggests one or a few names in accordance with his usual procedure.

There should be another pause here so that the patient may again voice his anxiety, objections, resentment or ask questions. The doctor may point out that he knows this is a new idea to the patient that well may upset him. If he cannot make up his mind he may be given a day or so to think it over and then return for further discussion. If he asks for the doctor's guidance then one may proceed with the referral. Thus the patient will feel that the doctor is sure of his opinion and willing to help him. He may bring up the old attitude that psychiatrists are for "crazy people." It may help to point out that the largest percentage of modern psychiatric practice is made up of cases like his (i.e., with a combination of nervousness and physical symptoms) and only a small percentage is composed of *mentally* ill people.

The last step follows the patient's having agreed to go and choosing with the doctor's help a psychiatrist. One may say a few words regarding one's confidence in this new physician and also perhaps give a brief description of him to form a picture in the patient's mind of what he may expect. This will also aid in reducing anxiety. It is well to point out that there are various treatment methods concerned primarily with working

* Medical Director, Territorial Hospital, Kaneohe.

** The remarks in this paper do not deal with handling the hospitalization or referral of certain severe psychotics. Such cases would be dealt with differently.

out the emotional basis for his difficulties by discussions of his past and present life experiences and stresses. It is best not to say what the psychiatrist *will* do or what the frequency will be, etc. The referring doctor does not know. He should speak only in general terms to introduce the patient to the new therapeutic methods. Thus he lets the new therapist plan and explain his own treatment technique. It will help if the doctor will urge the patient to speak with complete frankness and detail to the psychiatrist.

The doctor should point out that he will keep in close touch with the patient's case and will make his findings available to the psychiatrist. This demonstrates continuing interest on the part of the regular doctor. Some patients have felt that their doctor had an attitude of "getting rid of them" by sending them off to another physician and not following up. We should give them all the help needed in making the first appointment with the new therapist. Before the patient reaches the psychiatrist it is of great value for the doctor to call or write to the specialist a detailed summary of the findings and the patient's problem. This is particularly valuable if the doctor has had prolonged contact with the patient. The psychiatrist will need the physical and laboratory findings to help in his over-all evaluation of the case.

It cannot be emphasized too strongly that the way in which a referral is made may make a crucial difference in whether or not the patient accepts psychiatric treatment and in whether or not he profits from it. It is not a simple task. It is admittedly delicate. Its importance warrants considerable thought and time. The writer hopes this brief discussion will offer useful suggestions.

# Umi Makahiki I Hala*

## New Members

No reporting of new members has been made in this column since January 1943. We regret the omission and report here all members received during the fiscal year to date:

Regular Members

**Allison, Samuel D.**—Oregon 1936
**Bailey, Robert F.**—Arkansas 1940
**Eveleth, Barton M.**—Rush 1939
**Felix, John M.**—So. Cal. 1942
**Fernandez, L. R.**—Washington 1941
**Inamine, S.**—Chicago 1938
**Ito, William S.**—Oregon 1939
**Johnston, Robert G.**—Harvard 1937
**Kurashige, H. W.**—Northwestern 1939
**Lee, Edmund L.**—St. John's 1936
**Majoska, Alvin V.**—Penn. 1940
**Matsuyoshi, M.**—Louisville 1931
**Sanders, John F.**—Nebraska 1934
**Shanahan, William M.**—Wisconsin 1936
**Slaten, Edward F.**—McGill 1940
**Takenaka, K.**—Washington 1938
**Walsh, William**—Rush 1942

The Hawaii Dermatological Society was founded on February 5th, 1944, with **Drs. James T. Wayson, Frank L. Putman, Harold M. Johnson, Harry L. Arnold, Jr.,** and **Major Edwin K. Chung-Hoon** as charter members. Associate members joining were **Major Solomon Greenberg, Major Gerard De Oreo, Captain Herbert Lawrence, Captain David J. Musman, Captain L. H. Rosenthal** and **Captain Albert Shapiro,** all of the Medical Corps, A.U.S.

Drs. Smith and Buzaid recently organized a society of roentgenologists from among the medical officers in the Army and Navy and have had three meetings to date. Meetings are held once a month on the call of the Chairman, **Dr. Jesse W. Smith,** in the Mabel Smyth Building. **Dr. Louis Buzaid** is Secretary of the group.

**Dr. Takeo Fujii** has returned from Molokai and has joined his brother in practice at 1914 S. King St.

**Dr. C. Alvin Dougan** has been working these last months with **Dr. Rothwell** at Kahuku.

**Dr. A. Sumner Price** took over the laboratory at Queen's Hospital the latter part of the year as its director.

**Dr. Edgar Childs** has joined Dr. Saunders in his practice.

Doctors returning from the mainland recently were **Fred Alsup, C. S. Culpepper, Arthur Duryea, Harold Johnson** and **Cecil Saunders.**

**Dr. John H. Farrell** has been away from the islands for some months and is reported to be in Redwood City.

**Dr. Douglas Murray** is back at Paia, Maui, we are informed.

**Dr. Rodney T. West** has been transferred to the School of Aviation Medicine at Pensacola.

**Dr. J. W. McClellan** is reported to be at Fort Bliss, Texas.

**Dr. Verne C. Waite** of the USPHS is now in Lexington, Kentucky, at the USPHS Hospital there.

**Dr. Vergil Bradfield,** from the University of Maryland Hospital, took over his duties as administrator for the Kapiolani Maternity Hospital on April 1.

**Dr. Arthur A. St. Maur Mouritz,** Honorary Member of the Honolulu County Medical Society, contemporary and co-worker with Father Damien, died at the age of 88 at the St. Francis Hospital on December 1, 1943.

* Ten years ago. From Volume 3, Number 4, March-April, 1944.

# The Honolulu County Medical Library

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and at noon on Territorial holidays

## Recent Acquisitions

**Allergy**

Sammis, F. E. *The allergic patient and his world.* c1953. (gift of publisher).

**Anesthesia**

Moore, D. C. *Regional block.* c1953. (gift of publisher).

**Bacteriology**

Weil, A. J. *Salmonellae and shigellae.* c1953. (gift of publisher).

**Biochemistry**

Harper, H. A. *Review of physiological chemistry.* 4th ed. c1953. (gift of publisher).

Klendshoj, N. C. *Fundamentals of biochemistry in clinical medicine.* c1953. (gift of publisher).

**Biography**

Browne, D. G. *The scalpel of Scotland Yard.* c1952. (gift of Dr. Matsuoka).

Johnstone, R. W. *William Smellie.* 1952. (gift of Dr. Spencer).

**Cancer**

Goldman, L. B. *Fundamentals of clinical cancer.* c1953. (gift of publisher).

**Cardiology**

Lev, Maurice. *Autopsy diagnosis of congenitally malformed hearts.* c1953. (gift of publisher).

Ruskin, Arthur. *Physiological cardiology.* c1953. (gift of publisher).

**Dentistry**

Sicher, Harry. *Oral anatomy.* 2nd ed. c1952. (gift of publisher).

**Dermatology**

Downing, J. G. *The cutaneous manifestations of systemic diseases.* c1954. (gift of publisher).

**First Aid**

Cole, W. H. *First aid, surgical and medical.* 4th ed. c1951.

Murphy, F. D. *Medical emergencies.* 4th ed. c1952.

**Nursing**

Faddis, M. O. *Textbook of pharmacology for nurses.* 4th ed. c1953. (from Nurses' Association).

Faddis, M. O. *The mathematics of solutions and dosage, including simple arithmetic.* 3rd ed. rev. c1948. (from Nurses' Association).

Cooper, L. F. *Nutrition in health and disease.* 12th ed. c1953. (from Nurses' Association).

Heidgerken, L. E. *Teaching in schools of nursing.* 2nd ed. c1953. (from Nurses' Association).

Jensen, D. M. *Clinical instruction and its integration in the curriculum.* 3rd ed. c1952. (from Nurses' Association).

Montag, M. L. *Nursing arts.* 2nd ed. c1953. (from Nurses' Association).

**Obstetrics**

Crossen, R. J. *Diseases of women.* 10th ed. c1953. (gift of publisher).

Engle, E. T., ed. *Pregnancy wastage.* c1953. (gift of publisher).

**Orthopedics**

DuBrul, E. L. *The adaptive chin.* c1954. (gift of publisher).

Lewin, Philip. *The knee and related structures.* c1952. (gift of publisher).

Willis, T. A. *Man's back.* c1953. (gift of publisher).

**Pathology**

Ackerman, L. V. *Surgical pathology.* c1953. (gift of publisher).

Herbut, P. A. *Gynecological and obstetrical pathology.* c1953. (gift of publisher).

**Pediatrics**

Russ, J. D. *Resuscitation of the newborn.* c1953. (gift of publisher).

Zahorsky, John. *Synopsis of pediatrics.* 6th ed. c1953. (gift of publisher).

**Psychiatry**

American Psychiatric Association. *The psychiatrist, his training and development.* c1953. (gift of publisher).

Bender, Lauretta. *Aggression, hostility and anxiety in children.* c1953. (gift of publisher).

Burrow, Trigant. *Science and man's behavior.* c1953. (gift of publisher).

Noyes, A. P. *Modern clinical psychiatry.* 4th ed. c1953. (gift of publisher).

**Roentgenology**

deLorimier, A. A. *Clinical roentgenology.* v.1. c1954. (gift of publisher).

**Surgery**

Ficarra, B. J., ed. *Emergency surgery.* c1953. (gift of publisher).

# Book Reviews

### Man's Back.

By Theodore A. Willis, A.M., M.D., F.A.C.S., 161 pp., illustrated, Price $9.50, Charles C. Thomas, 1953.

In this excellent treatise, the author draws from his years of experience coupled with accurate facts to produce a practical and useful monograph. The book is complete as to essential facts but is brief and clear in its description of embryology, anatomy, mechanics of the back, diagnosis and management. He has even devoted sections to psychoneurosis and malingering.

The pictures are excellent and the clinical entities are well illustrated with x-rays, pathological specimens and pictures of actual patients. As comprehensive and well written as this book is, there are only 158 pages from cover to cover. This is the type of book a physician likes to review section by section in the evening hours of leisure.

ROBERT C. H. CHUNG, M.D.

### Surgical Pathology.

By Lauren V. Ackerman, M.D., 836 pp., illustrated, Price $14.50, C. V. Mosby Company, 1953.

This excellent book on general aspects of surgical pathology is apparently written not for medical students but for physicians, especially surgeons and pathologists who have had some experience in the problems of practice. Illustrations and descriptions of gross pathology have been stressed throughout, with superb clinicopathologic correlations. Microscopic descriptions are brief, but supplemented by numerous photomicrographs of top quality. The many illustrations are typical of various surgical conditions although, in instances, the author has been unable to resist showing some of the more interesting and rare lesions. Frank discussions are presented regarding indications for and validity of interpretation of frozen sections: for example, in lesions of the thyroid. All in all, this reviewer was so impressed with the excellency of this book that he purchased a copy for his own shelves and recommends it above any other text of surgical pathology for those physicians practicing surgery.

RAID CHAPPELL, M.D.

### Psychological Factors in the Care of Patients with Multiple Sclerosis.

By M. R. Harrower, Ph.D., and Rosalind Herrmann, B.A., 32 pp., National Multiple Sclerosis Society, 1953.

This pamphlet published and made available by the National Multiple Sclerosis Society concisely discusses the various psychological aspects of the patients with multiple sclerosis—the so called "MS Personality." Very uniquely it also discusses the doctor-patient relationship from the psychological aspect.

It is a valuable adjunct to any doctor's library as the psychological problems discussed may be utilized in other neurological disorders.

TORU NISHIGAYA, M.D.

### Synopsis of Pediatrics.

By John Zahorsky, A.B., M.D., F.A.A.P., Sixth Edition, 470 pp., illustrated, Price $7.50, C. V. Mosby, Company, 1953.

This book is recommended to doctors who are teaching medical students or nurses. It is also recommended for studying for pediatric examinations—both written and oral. It is a good book for a quick review for lectures to internes, residents, and nurses, and for short talks to local organizations.

It is not recommended to the practicing physicians or pediatricians for practical applications to clinical cases, since the treatments are very brief and do not contain the dosages and indications of modern drugs. The print in the book is smaller than normal and hence long spells of reading from it are not recommended.

W. T. CHOCK, M.D.

### Diseases of Women.

By Robert James Crossen, A.B., M.D., F.A.C.S., Tenth Edition, 935 pp., illustrated, Price $18.50, C. V. Mosby Company, 1953.

The 10th edition reveals re-editing and countless timely revisions of a book, already widely known, originally written by Dr. H. S. Crossen. Noteworthy are the additions of recent knowledge in the fields of endocrinology, embryology, gynecological anatomy, therapy, physiology, diagnostic aids in the field of women's diseases and the psychosomatic aspects of gynecological problems.

The section on gynecological examination and diagnosis is outstanding, and it behooves every practitioner who does any gynecology to peruse this chapter, which covers the subject thoroughly and precisely. The chapter is profusely illustrated, as is the whole book, in both black and white and color.

In recent years more interest and appreciation is noticed in the psychosomatic aspect of gynecology. This is most evident in the chapters entitled "Menstrual Disturbances" and "Sterility and Sexual Disturbances."

EDWARD T. MATSUOKA, M.D.

### Physiological Cardiology.

By Arthur Ruskin, M.D., 370 pp., illustrated, Price $8.00, Charles C. Thomas, 1953.

This monograph is a summation of the most recent ideas and advances in the field of physiological cardiology as it relates to the various types of cardiovascular diseases. Thus, through a better recognition of the physiopathology involved in the mechanisms of heart disease, the author feels that more logical and appropriate therapeutic measures can be applied. Numerous formulas and physical laws are included, essentially those of general acceptance rather than those of still controversial nature. The virtue of presenting such a wealth of ideas within a relatively few pages undoubtedly created this book's chief fault; for each page and paragraph bristles with such numerous facts, ideas and formulas that reading is extremely slow and tedious.

THOMAS S. MIN, M.D.

## The Knee and Related Structures.

By Philip Lewin, M.D., F.A.C.S., F.I.C.S., 914 pp., illustrated, Price $16.00, Lea & Febriger, 1952.

The text of these some 871 pages is ably summed up in the preface, in which Dr. M. S. Henderson of the Mayo Clinic says, "there is nothing I can add to what Dr. Lewin will say." Of primary interest to the orthopod, this work might well serve as a source book of knee joint pathology and therapy for the general surgeon.

In so writing this book, it was Dr. Lewin's objective to "digest, correlate, integrate, and evaluate" all that has been written or discussed in regard to the knee joint. His own enthusiasms, as to just how "stimulating" this book will be, may be needed by the reader as he approaches page 800.

For the doctor with the extra $16, however, this is an excellent reference book and a good addition to any library. The illustrations are well done and the charts comprehensive and numerous. The suggested additional reading references found throughout the text are somewhat of an innovation and serve to make it even more the encyclopedia. Suggested dosage: small, and p.r.n.

JOHN W. HOWARD, M.D.

## The Allergic Patient and his World.

By Florence Eastty Sammis, M.D., 156 pp., Price $4.75, Charles C. Thomas, 1953.

This excellent little treatise presents clearly and briefly the fundamentals of the allergies, their manifestations and methods of treatment, and many helpful hints for the allergic patient as well as for the practitioner who treats such disorders. In its original form it was privately printed for use of the author's patients. It answers most questions that a patient may ask regarding his or her allergic manifestations.

The chapters on pollens are an excellent guide for those who practice on the mainland, and as a very handy reference work for medical men in the Islands when questioned about pollen situations in various sections of the country.

Chapters on "Special Instructions" for allergic patients and on elimination diets and other forms of dietary regimen, as well as "Recipes," are excellent and most helpful in the handling of this type of constitutionally ailing individual.

The book is highly recommended to those who wish to avail themselves of a handy, concisely written reference work on the allergic patient, his disease and how he can live with his troubles in this modern world.

TELL NELSON, M.D.

## Fundamentals of Biochemistry in Clinical Medicine.

By Niels C. Klendshoj, M.D., 276 pp., illustrated, Price $7.75, Charles C. Thomas, 1953.

This book has a simple and rapid summary of some of the fundamental principles of biochemistry. Following this, there is relationship of these fundamentals to clinical medicine. The book is a quick reference and contains an excellent bibliography for further study. It is an excellent acquisition for a library and for those who wish a rapid review or refresher concerning certain aspects of biochemistry in medicine. Physically, the book is well bound, the print is legible, and formulas are easily followed. Tabling, graphing and charting are utilized in the production of the work.

W. HAROLD CIVIN, M.D.

## Clinical Roentgenology — Volume I.

By Alfred A. DeLorimier, M.D., Henry G. Moehring, M.D., and John R. Hannan, M.D., 495 pp., illustrated, Price $18.50, Charles C. Thomas, 1953.

Objectively this volume represents an effort to simplify radiographic diagnosis. The method incorporates embryonic and etiologic basic processes, assimilates minor variants, eliminates ambiguous terminology and stresses the consistent roentgenographic characteristics of a lesion. Corroboration of the laboratory, clinical and radiographic features is emphasized and these are correlated succinctly. The general theme accentuates intelligent evaluation of a radiograph, which is contingent upon complete knowledge of the clinical history and all phases of the physical examination. Differential diagnosis is presented briefly stressing constant discrepancies between the lesions under consideration. Illustrations (which outnumber the pages) are large, clear reproductions of original roentgenographs.

LOUIS L. BUZAID, M.D.

## Emergency Surgery.

Edited by Bernard J. Ficarra, A.B., Sc.B., M.D., 1000 pp., illustrated, Price $18.00, F. A. Davis Co., 1953.

To provide a directive to guide every physician in the handling and management of emergency situations, Dr. Ficarra and a collaborating list of specialists have created a definitely useful book. Because the various chapters are written by different men, each an authority in his own field, the text has much more authority than that written by any one person or group.

Emergency situations, from those due to sudden catastrophe or accident to those which arise during the performance of routine surgical procedures, are covered very well. Reading is easy, and the material up-to-date.

There is an interesting section on cardiac arrhythmias during anesthesia with some of the problems resulting therefrom.

For every one of us who deals with surgical emergencies, this book will be of value. A whole list of bibliographies is attached at the end of each chapter for more selective reading. I would recommend this book to all physicians.

ROY T. TANOUE, M.D.

## The Practical Management of Diabetes.

By Edward Tolstoi, M.D., 93 pp., Price $3.25, Charles C. Thomas, 1953.

Dr. Tolstoi is perhaps the chief advocate in the United States of a self-selected, unmeasured, and unweighed diet. He disregards the height of the blood sugar and the amount of sugar spilled in the urine.

He briefly outlines his manner of treating acidosis and coma, the diabetic requiring surgery, the pregnant diabetic, and the vascular and neurological complications of diabetes. The last chapter is a discussion of whether hyperglycemia and glycosuria per se cause diabetic complications.

This monograph is not too well written in my opinion and I was a little disappointed that he had so little statistical evidence to back up this rather radically different way of treating diabetes. Only added time and careful clinical evaluation will determine whether the total disregard of a patient's blood sugar has a place in the management of diabetes.

ELMER C. JOHNSON, M.D.

### Physiological Methods in Clinical Practice.

By William S. Middleton, M.D., 40 pp., Price $1.00, Charles C. Thomas, 1953.

This book is a reprint of a lecture given by Dr. Middleton before the Wayne County Medical Society, called the Beaumont Lecture. It was delivered on February 2, 1953.

Taking as a springboard the inspiring story of William Beaumont, who had never attended a medical school and whose entire medical education consisted of having practiced as an apprentice to another physician for two years, Dr. Middleton discusses one after another of the various physiological discoveries which have proven to be of importance in the diagnosis and treatment of disease, giving in each instance a brief account of the history and development of this branch of knowledge and in each case bringing it up to date. Really, the theme of the entire book is the importance of physiology in both health and disease as far as clinical practice is concerned, and the importance of objective observations unswayed by prevalent theories of disease which claim to be all-explanatory. The booklet is as fascinating to read as any whodunit and may be read with equal pleasure and profit by a senior medical student or by a physician who has been in practice—like the reviewer—for more than forty years.

One delightful and useful feature is exemplified by his discussion of liver function tests. Many of us have tended to become rather discouraged about the enormous battery of them required and about our failure to arrive at a diagnosis in spite of the utilization of as many of them as our laboratory was able or willing to conduct. Dr. Middleton succeeds in separating these into the sheep and the goats, giving you as clear an idea as is possible in this extremely short paragraph of what conclusions you may draw from the findings.

I have ordered a half dozen copies to give away to young physicians of my acquaintance.

H. L. Arnold, Sr., M.D.

### Tumors of the Central Nervous System.

By James W. Kernohan, M.D., and George P. Sayre, M.D.

### Tumors of the Male Sex Organs.

By Frank J. Dixon, M.D., and Robert A. Moore, M.D.

### Tumors of the Lower Respiratory Tract.

By Averill A. Liebow, M.D.

### Tumors of the Thyroid Gland.

By Shields Warren, M.D., and William A. Meissner, M.D.

### Tumors of the Parathyroid Glands.

By Benjamin Castleman, M.D., Armed Forces Institute of Pathology.

These atlases are a continuation of the Armed Forces Institute of Pathology series on tumors and carry on the aims of all the preceding works. They all are well written and excellently illustrated. A special note is made of the one on the central nervous system wherein the new simplified Kernohan classification is stressed. Also of note is the work on the male sex organs which is the culmination of the work of Dr. Moore, now assisted by Dr. Dixon. The one on the respiratory system by Liebow is of great interest and merit. The volume of Tumors of the Thyroid by Warren crystallizes his ideas and presents tumors of the thyroid in an understandable and workable fashion. The volume on parathyroid presents the problems of these rare tumors. The books are still paper backed and the pages contain perforations; the sheets are stapled in place. The print is legible, and the pictures are clear.

W. Harold Civin, M.D.

### Modern Clinical Psychiatry.

By Arthur P. Noyes, M.D., Fourth Edition, 609 pp., Price $7.00, W. B. Saunders Company, 1953.

This third revision of the now-standard text by Noyes, president-elect of the American Psychiatric Association, is moderately expanded in size: 75 more pages, and finer print. The over-all view of both disturbed and normal mechanisms of adjustment has grown also, largely in depth, with more extensive discussion of the psychological functioning of the personality and its origins. He feels, however, that "mental expressions of life are no less biological than physical ones." The organization of the book closely follows the American Psychiatric Association's newly standardized nomenclature, with cogent exposition of many vital concepts. Finally, I was impressed by the balance of the perspectives presented, with adequate coverage of theories and methods in both psychoanalysis and physiological therapy for a book of this scope. It is an excellent first book in psychiatry, but equally good for one seeking a realistic, up-to-date view of the field.

James G. Harrison, M.D.

### Resuscitation of the Newborn.

By Joseph D. Russ, M.D., 55 pp., illustrated, Price $2.50, Charles C. Thomas, 1953.

Pediatrician Russ has written a thorough and scientific discussion of the definitions, causes, treatments, and after effects of neonatal asphyxia. The chapter on resuscitation contains sound recommendations for physicians handling newborns. Dr. Russ' forte is intratracheal catheterization and aspiration, especially in cesarean section newborns; but he neglects to mention that the procedure is difficult unless the baby is flaccid, and fails to caution on the danger of causing edema of the vocal cords. Aspiration of the stomach in these infants, a valuable procedure, is not discussed. Undoubtedly some physicians will not agree with the author in his criticism on some of the methods used in stimulating the infant to initiate the all-important first gasp of life.

This easily read, short monograph emphasizes the importance of newborn handling and makes a plea for training residents and interns in the principles and art of resuscitation. In spite of a few omissions, the subject is well handled and makes a valuable addition to the physician's library.

Ted W. S. Chong, M.D.

### Mechanisms of Urologic Disease.

By David M. Davis, M.D., 156 pp., Price $4.50, W. B. Saunders Company, 1953.

This is a brief and concise review of the various pathological entities encountered in the genito-urinary system. The author's interesting approach is one which deals with the etiologic mechanical factors in genito-urinary disease, both theoretical and actual. Each subject is covered, though lacking much detail. It no doubt would interest the practitioner who practices urology only on occasion. The practicing urological surgeon, however, would no doubt consider the author's approach somewhat elementary.

Andrew L. Morgan, M.D.

### Salmonellae and Shigellae.

By Alfred J. Weil, M.D., and Ivan Saphra, M.D., 247 pp., illustrated, Price $7.75, Charles C. Thomas, 1953.

The principles and procedures for antigenic typing of Salmonellae and Shigellae, together with the clinical and epidemiologic significance of these enteric bacterial pathogens, are clearly presented. Although the book is directed primarily to the laboratory worker, the nature of the data and discussions presented is such as to stimulate the clinician to a better utilization of laboratory services and appreciation of the multiplicity of bacterial types associated with enteric disease and food-poisoning.

MAX LEVINE, Ph.D.

### Pregnancy Wastage.

Edited by Earl T. Engle, M.D., 254 pp., illustrated, Price $8.50, Charles C. Thomas, 1953.

The title of the book has been used to indicate the total post-conceptional reproductive deficit. This book is very well organized and covers the subject from experimental work in the Rhesus monkeys to actual clinical work in the larger medical centers. This book has many contributors, all of whom are well-recognized as leading men in their fields. There is no answer to all the questions we would like to know. However, after reading this book, one cannot help but understand the problem better. There is an excellent section on ACTH and Cortisone in pregnancy. This book is recommended for anyone interested in pregnancy wastage.

GAIL LI, M.D.

### Regional Block.

By Daniel C. Moore, M.D., 373 pp., illustrated, Price $11.00, Charles C. Thomas, 1953.

This is an extremely readable, well-organized and authoritative discussion on the various commonly accepted regional anesthesia techniques and procedures. Included in its pages is also an excellent discussion on diagnostic and therapeutic pain problems. The outstanding features of the book are its conciseness and clarity and its excellent illustrations. Surgeons, anesthesiologists, and more especially busy general practitioners will all find this book of great value in their daily practice of medicine. The only adverse criticism I have is that the pre-medication and the equipment needed for each special local procedure are constantly repeated, to the point of being monotonous.

E. WONSIK YOU, M.D.

### The Cutaneous Manifestations of Systemic Diseases.

By John Godwin Downing, M.D., 146 pp., illustrated, Price $4.25, Charles C. Thomas, 1953.

A bird's eye view of a wide variety of skin lesions resulting from underlying systemic disease is provided in this attractive pocket-size volume. The material, taken from the wide experience of a leading American dermatologist, is authoritative, and is straightforwardly presented in plain language. The material is divided into chapters according to the nature or cause of the underlying disease, with two exceptions: one chapter deals with color changes in skin and mucous membranes, and one with the five major sclerosing skin diseases. A five-page chart clearly distinguishes these last from one another. Concern is primarily with diagnosis throughout the book, though illustrative case reports are frequently used and often explain suitable treatment.

The style suffers occasionally from excessive casualness: for example, tongue lesions are lumped in a single paragraph in the chapter on color changes; Plummer-Vinson syndrome is mentioned only in this connection, not again under anemias (though spoon nails are mentioned there); and in the same paragraph with the tongue lesions occur two sentences on excessive sweating, which seems a little remote from both color changes and tongue lesions.

The spelling of Fröhlich's, hemofuscin, scarlatiniform, ecthyma, l.e. disseminatus, Jonathan, erythema multiforme bullosum, Coccidioides, and coccidioidomycosis might well be corrected in a second edition, and such an important subject as purpura might well be given more than the single paragraph now allotted to it. These are minor points, however; the book is a useful and practical reference manual which could be read with profit by any general practitioner and most dermatologists.

HARRY L. ARNOLD, JR., M.D.

## Also Received

### Surgical Clinics of North America.

December, 1953, Philadelphia Number — Orthopedic Surgery, pp. 1543-1828, figs. 452-561, $18 per clinic year, cloth binding, $15 per clinic year, paper binding, W. B. Saunders Company, 1953.

### Aggression, Hostility and Anxiety in Children.

By Lauretta Bender, B.S., M.A., M.D., 182 pp., illustrated, Price $5.50, Charles C. Thomas, 1953.

Indispensable to the child psychiatrist.

### The Adaptive Chin.

By E. Lloyd DuBrul, D.D.S., M.S. and Harry Sicher, M.D., D.Sc., 97 pp., Price $3.50, Charles C. Thomas, 1953.

For anthropologists and perhaps also orthodontists.

### Science and Man's Behavior.

By Trigant Burrow, M.D., Ph.D., 564 pp., illustrated, Price $6.00, Philosophical Library, Inc., 1953.

Human race analyzed in 535 pages. Fascinating but long and very deep.

### The Psychiatrist, His Training and Development.

Report of the 1952 Conference on Psychiatric Education organized and conducted by the American Psychiatric Association and the Association of American Medical Colleges, 214 pp., American Psychiatric Association, 1953.

For the would-be psychiatrist.

### Music Therapy.

Edited by Edward Podolsky, M.D., 335 pp., Price $6.00, Philosophical Library, 1954.

It goes much further than you'd think.

# HMSA—Its Place in the Community

## Increased Benefits to Members

J. R. VELTMANN, *General Manager*

It was most gratifying to HMSA to be able to provide its members with a "DIVIDEND" in the form of increased benefits effective January 1, 1954. This is the second consecutive year in which the Association has presented a dividend to its members without any increase in the monthly premium. As a non-profit organization, all dues income over the amounts needed for operating expenses and reserves is returned to the member through increased benefits or reduced premiums. Dividends provided in the past two years were the result of a large increase in membership, excellent cooperation of participating physicians and participating hospitals, and the plan's successful efforts in keeping operating costs at a minimum.

The most important additional benefit included was the extension of our services for chronic or pre-existing conditions. It is significant to note that up to July 1, 1951, treatment or surgery for a pre-existing condition was not covered as a benefit and chronic conditions were covered for limited benefits only under the plan. In a sample survey of membership in 1948, it was indicated that there was a great need for some protection for pre-existing conditions. It was also brought out at the time that this exclusion proved to be a difficult administrative problem.

Statistical and other records were immediately established and maintained, and after an eighteen months' study it was determined that the cost of covering pre-existing conditions in full would force HMSA to increase its rates beyond the ability of members to pay for their medical plan coverage. The plan decided to offer partial coverage for these conditions, and effective July 1, 1951, members were offered up to $200.00 for medical surgical or hospital benefits after the member had been in the plan for a period of one year.

In the meantime, studies were continued on chronic and pre-existing conditions to determine the additional cost of covering such conditions in full. After another eighteen months' period, statistics proved that HMSA could cover surgery and hospitalization in connection with surgery for chronic and pre-existing conditions for a slight increase in premiums. However, in view of favorable operations, this additional benefit is offered without increased dues. Statistics indicate that the plan is not in a position to cover continuous medical treatment for chronic medical illness such as coronary disease, diabetes, arthritis or asthma for prolonged periods without effecting a heavy increase in premiums. In view of this, the plan will continue to limit medical treatment of a chronic medical illness to a period of sixty calendar days, but has extended its hospital benefits for such chronic conditions to allow a maximum of $200.00 for such chronic medical illnesses. HMSA will continue to analyze the costs of covering chronic medical illnesses and if possible, increase these benefits in the future.

Several other restrictions were removed and for the Comprehensive Plan, additional hospital benefits were added. With these improvements, most of the limiting provisions of the plan have been eliminated to give the member the best possible coverage for the dollar invested.

HMSA sincerely believes that with continued public support of the plan and continued cooperation from participating physicians and hospitals, its ultimate objective of offering the people of Hawaii the *best* medical plan for the lowest possible cost will be reached. Public interest in HMSA has been proven by the fact that HMSA has realized a net gain of approximately 20,000 members in the last two years.

# Hawaii Medical Association

## HOUSE OF DELEGATES MEETING

**Friday, January 22, 1954, at 7:30 P.M.**
**Mabel Smyth Building**

*Present:* Dr. Chung-Hoon presiding; Drs. Ito, Samuel Yee, Richert, Hayashi (Hawaii), Felix, Freeman, Joseph Lam, Dodge, West, Choy, Wiig, Marnie, Gebauer, Bailey, Wallis (Kauai), Ferkany (Maui), Burden (Maui), McCorriston, Kaneshiro, Walter Chung, Depp, Thomas Chang; also Drs. R. B. Faus, Waite, Dean Walker, Durant, Homer Izumi and Giles.

*AMA:* Dr. Izumi, delegate to the AMA, reported on the recent interim session in St. Louis.

*1956 Centennial:* Dr. Chung-Hoon called the delegates' attention to the fact that the Hawaii Medical Association was incorporated in 1856 and will therefore celebrate its centennial in 1956. Since that would normally be the year for an annual meeting on Kauai, the possibility of changing the 1956 meeting place to Honolulu was considered.

Dr. Wallis reported it had been unanimously decided by the Kauai Society the meeting should be held in Honolulu. They also felt the president should be from the Honolulu Society that year. Kauai would be glad to entertain the Association the following year.

**ACTION: It wos maved, seconded and corried thot the onnuol meeting be held in 1956 in Hanalulu and thot the president for that year be elected from the Hanalulu Caunty Medicol Saciety; alsa that the 1957 meeting would be held an Kauoi.**

Dr. Chung-Hoon felt it would be important to have a Centennial Committee at work well in advance of the 1956 meeting. He thought that if this committee began their work in 1954 and continued into 1956, it would be proper for the Delegates to designate such a committee.

**ACTION: It wos maved, seconded and corried that the motter of setting up a Centennial Committee be postponed until the May annuol meeting, so that the afficers moy study the situatian and bring their recommendations ta the delegates in Moy, follawing the suggestian by Dr. Richert thot the new president-elect be choirman af the Committee.**

*Medical Education Foundation*: The chairman presented a resolution urging support of the American Medical Education Foundation.

**ACTION: The following resalutian wos odopted an matian of Dr. Yee:**

**Whereos, The American Medical Educatian Faundotion hos been established by the American Medical Associotion ta pramate the ort and science af medicine ond the betterment af public health by praviding ar oiding in the providing af finonciol oid to recagnized schools ar institutians af medicol educotion respansible far the educotion and training af the physicions of the United Stotes; ta distribute funds, monies or cantributians ta medical schaals; ond ta determine the amaunt, manner and conditions in which ond under which oll avoiloble funds will be distributed ta eligible schaals; ond**

**Whereas, The great need for unrestricted funds in suppart of medicol educotion is recognized by the medical professian in arder ta cambat the possible socialization af medicol educotion by federal subsidies; and**

**Whereos, Every cent contributed ta the American Medicol Education Faundotion goes to the medical schoals ond is deductible in camputing toxoble net income; and**

**Whereas, Contributions to the Foundotian moy be earmarked for ony of the 79 oppraved medical schaols; naw therefore, be it**

***Resolved,* Thot the Hawoii Medicol Assaciotian appraves of the purposes af the Americon Medicol Educotion Faundation ond urges its members ta cantribute generausly to medical schoals through this Faundotian or directly ta the medical schools.**

*Mabel Smyth Building:* Dr. Chung-Hoon introduced a resolution to authorize the retirement of the Hawaii Medical Association in favor of the Honolulu County Medical Society as a guaranteeing party to the maintenance of the Mabel Smyth Building. Following a discussion of adopting the resolution after legal advice, Dr. Ito said he thought the doctors should be very careful before transferring this responsibility from the parent association to a component society. He said that he was speaking for Dr. Larsen who was unable to be present. This building is a symbol of the prestige of the medical profession in the Territory, he said. If such a change were made, he felt the doctors from other islands would then be guests instead of feeling that this was their building also. The building was originally meant for the Territory and Dr. Ito stated he was not sure the Honolulu County Medical Society would wish to accept the responsibility.

**ACTION: Dr. Yee moved thot the question be tobled. This was seconded by Dr. Lam and possed with 1 dissenting vate.**

Dr. West suggested that the Territorial Association ask the advice of the Honolulu County Medical Society President when making an appointment to the Mabel Smyth Board.

*Standard Fee Schedule:* Dr. Chung-Hoon introduced a resolution to provide for a standard fee schedule of the Territorial Medical Association for individuals with an income of $4800 or less. During the discussion of this subject, Dr. West mentioned the difference in overhead on other islands and the fact that the doctors now have an HMSA and a Workmen's Compensation Fee Schedule to use as guides. It was also pointed out that there are wide variations in overhead of doctors even within Honolulu, as well as differences in the type and quality of practice.

Dr. Faus spoke of the difficulty of making a complete fee schedule. He also mentioned new bills introduced

in Congress regarding reinsurance for health insurance plans and assistance to hospitals.

**ACTION: It was agreed to table the resolution.**

Dr. Chung-Hoon summed up the discussion, saying that many helpful views had been expressed, but that in the final analysis, better public relations depend on the individual doctor's approach to each patient.

*Industrial Relations:* Dr. West stated that there was no committee in this organization investigating the effects of unions on the practice of medicine. He spoke of an HMSA Medical Committee meeting with management representatives a week ago in which this was discussed. Dr. West also felt the doctors had not been informed of developments in industrial medical care.

At Dr. Dodge's request, Dr. West read a section from the minutes of the HMSA Medical Committee, including this statement: "In view of the fact that the Industrial Relations Committee has not fulfilled its purpose, the Chairman felt that this matter should be brought to the attention of the Territorial Medical Association."

Dr. Chung-Hoon outlined the foundation of the Industrial Relations Committee and stated that he felt both the Industrial Relations Committee and the HMSA Medical Committee have fulfilled their functions as authorized by the Medical Association.

Dr. Ito said he was present at the HMSA meeting and felt that the statement made in the HMSA minutes was incorrect because he had made it clear to them at the meeting that the functions of the Industrial Relations Committee were carefully and clearly defined at the time it was created and he believed they were not derelict in their duty.

Dr. West asked what project the Industrial Relations Committee was carrying on now. Dr. Dodge replied they were evaluating the various insurance companies operating in the Territory—not just HMSA.

After further discussion, it was generally agreed that the Industrial Relations Committee was fulfilling its functions and should continue in the same capacity.

Dr. Dodge said his committee has presented reports and recommendations to the Territorial Medical Association at its annual meeting but had no other means of bringing important developments to the attention of the doctors.

Dr. Durant brought out that the Public Relations and later the Public Service Committee used to disseminate such information to the members, and suggested that this again be done through the Public Service Committee. Dr. McCorriston agreed his committee would be glad to do so.

The meeting adjourned at 10:50 p.m.

SAMUEL L. YEE, M.D.
*Secretary*

## COUNCIL MEETING

**Tuesday, February 2, 1954 at 4:15 P.M.**
**Mabel Smyth Building**

*Present:* Drs. Chung-Hoon, N. P. Larsen, S. L. Yee, Richert, Ito, Gotshalk, and H. Benson; also Dr. Vasconcellos.

*Audio-Digest:* Dr. Vasconcellos presented details of tape recordings and film strips available from the Audio-Digest Foundation, a subsidiary of the California Medical Association.

**ACTION: Dr. Gotshalk moved that the Postgraduate Committee explore the possibility of acquiring the apparatus necessary for participation in the Audio-Digest program. It was suggested that the assistance of the Honolulu County Medical Society be asked in evaluating the project and that 2 or 3 tapes be bought to try them out. The motion was seconded by Dr. Larsen and passed.**

*Mrs. Florence Sueoka:* A letter from Mr. Kennedy, executive secretary of the Honolulu County Medical Society, was presented in which he stated that the proposed 1954 budget of that society deleted the $62.50 monthly salary paid to Mrs. Sueoka. The Bureau of Medical Economics expects to have personnel to assist in the County Society's work. The Hawaii Medical Association was asked whether it could assume her entire salary.

**ACTION: On motion of Dr. Larsen, seconded by Dr. Richert, it was agreed that the Hawaii Medical Association would assume Florence Sueoka's entire monthly salary of $235 beginning March 1, 1954.**

*Red Cross:* Mrs. Bennett reported that she had received an oral request from the Red Cross for an endorsement by the Medical Association because of the approaching Red Cross Drive.

**ACTION: Dr. Richert moved that the secretary send a letter to the Red Cross saying that while the Council agrees the Red Cross is a worthy organization and urges the doctors to support it, it cannot speak for the Association in endorsing any other organization.**

*Academy of Science:* It was inadvertently omitted from the Council minutes of August 6, 1953 that the Council voted unanimously to accept an invitation to the Hawaii Medical Association to become affiliated with the Hawaiian Academy of Science as an Associated Society. With this correction, the minutes of the last Council meeting were approved.

*1956 Centennial Committee:* The president announced that the House of Delegates will appoint a Centennial Committee to develop plans for our centennial meeting in 1956. Suggestions of names for such appointment would be welcome. Dr. R. K. C. Lee has offered the services of the Health Department in developing a centennial program. Dr. Gotshalk recommended that there be very close liaison with the Honolulu County Medical Society. The Postgraduate and Public Service Committees would be interested and helpful.

SAMUEL L. YEE, M.D.
*Secretary*

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1. Hild, A. M.: Schweiz. med. Wchnschr. 71:557, 1941.
2. New and Nonofficial Remedies, J. B. Lippincott Co., Philadelphia, 1953, p.

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1. Dill, J. L.: Postgrad. Med. 4:413, 1948.

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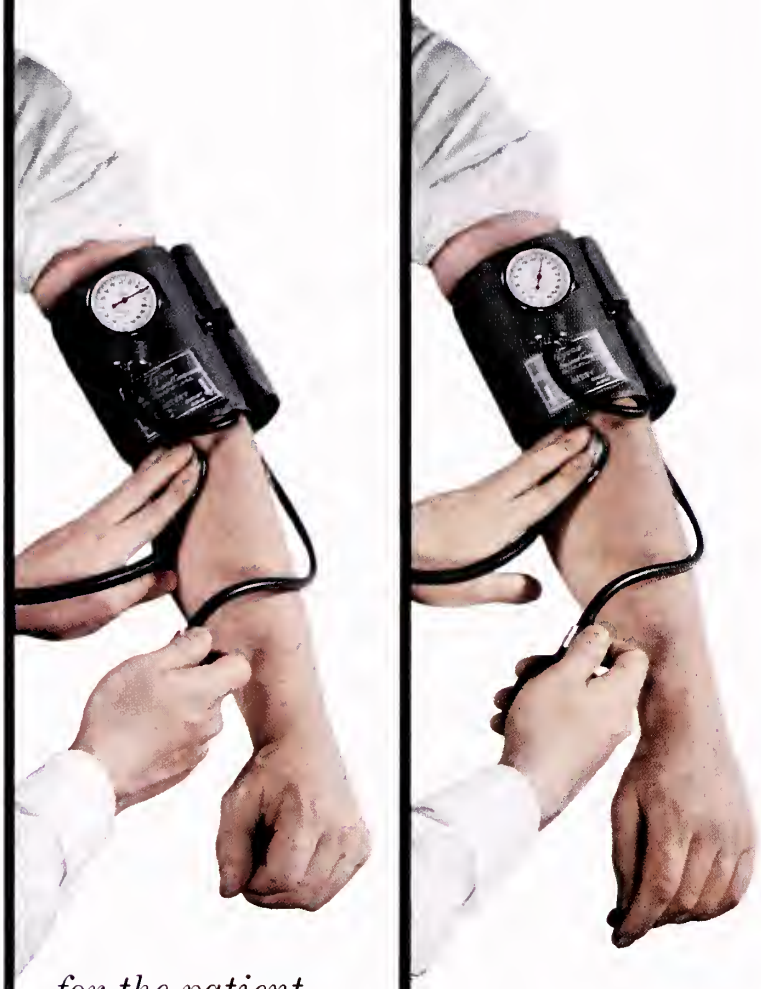
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1. Hafkenschiel, J. H., and Lindauer, M. A.: Circulation 7: 52, 1953.
2. Schroeder, H. A.: Circulation 5: 28, 1952.
3. Riven, S. S., Pocock, D. G., Kory, R. C., Roehm, D. C., Anderson R. S., and Meneely, G. R.: Am. J. Med. 14: 160, 1953.
4. Taylor, R. D., Dustan, H. P., Corcoran, A. C., and Page, I. H.: Arch. Int. Med. 90: 734, 1952.


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# County Society Reports

## HAWAII COUNTY MEDICAL SOCIETY

The monthly meeting of the Hawaii County Medical Society was held on Thursday, October 22, at the Hilo Memorial Hospital conference room at 7:30 p.m. Members present were: Doctors Bergin, M. H. Chang, Crawford, Haraguchi, Kasamoto, Leslie, Loo, Miyamoto, Ota, Oto, Stemmermann, Steuermann and Yuen.

Guests present were members of the Advisory Committee to the Bureau of Maternal and Child Health—Dr. S. Nishijima (chairman), Doctors K. S. Tom, H. E. Bowles, H. M. Patterson, W. Walsh (all of Honolulu); and J. I. Knox (Lanai).

The meeting began by Dr. Nishijima presenting a case. A round table discussion about the handling of toxic patients in the hospital followed. After this discussion, the method of caring for diabetic pregnant women was discussed.

Dr. Irvin Rothrock's application for membership to the Hawaii County Medical Society was unanimously accepted.

* * *

A dinner meeting of the Hawaii County Medical Society was held on Thursday, December 17, at 6:30 p.m. at the Naniloa. Members present were: Doctors Bergin, Crawford, Hayashi, Henderson, Jenkin, Kasamoto, Kaufmann, Kutsunai, Mitchel, Miyamoto, Okumoto, Ota, Oto, Stemmermann, Steuermann, Wong, Yuen, Oakley and Rothrock. Guests present were: Dr. Raymond deHay, and Dr. Ross H. Gary.

The announcement from the American Diabetic Association about the diabetic detection drive for 1953 was read. Dr. Yuen moved that because diabetic detection is being practiced day by day, it is not necessary to have a drive at this time. Motion was seconded by Dr. Okumoto and passed.

Dr. George D. Oakley's application for membership to the Hawaii County Medical Society was unanimously accepted.

A letter from the Woman's Auxiliary was read in which the Woman's Auxiliary asks for the approval of the members of the Society for the Auxiliary to prepare the biographies of the doctors on this island. It was moved by Dr. Bergin and seconded by Dr. Okumoto that the members of the Hawaii County Medical Society approve of this project.

The recommendations of the Advisory Committee to the Bureau of Maternal and Child Health and to the Bureau of Crippled Children were accepted as presented.

Dr. Steuermann reminded members that effective November 1, 1953, the indigent program was not able to pay for the hospitalization for medical indigents due to shortness of funds and they will pay for hospitalization for only the welfare patients. In order to remedy this situation, it was proposed that a committee of three be appointed, which committee could evaluate the status of indigents and medical indigent patients in any of the county hospitals when referred to them for evaluation by the Office of Medical Social Worker. The above proposal was put to motion by Dr. Crawford and seconded by Dr. Yuen. Dr. Hayashi appointed the following members to serve on this committee: Doctors Stemmermann, Crawford and Bergin.

Dr. Stemmermann announced that the consultation services by internists will be available monthly at the Hilo Memorial Hospital and asked the members for a motion to approve these consultation services. It was moved by Dr. Yuen and seconded by Dr. Okumoto that this Society recommends the services of the internist for consultation.

Dr. Hayashi introduced Dr. Raymond deHay from Honolulu who gave a very interesting talk on "Differential Diagnosis of Jaundice."

NICHOLAS STEUERMANN, M.D.
*Secretary*

## HONOLULU COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Society was held in the Mabel Smyth Auditorium on Thursday, January 7 at 8:00 P.M. Dr. William S. Ito presided and approximately 125 members and guests attended.

The Staff of Tripler Army Hospital presented an excellent scientific program:

*Massive Bleeding from the Upper GI Tract*
Lt. Colonel Robert C. Hunter, Jr.

*Management of Large Bowel Polyps*
Capt. Roscoe E. Mason

*Pathogenesis and Treatment of Diabetic Coma*
Major Ervin A. Kjenaas

Following the program, refreshments were served on the lanai.

* * *

The regular monthly meeting of the Society was held in the Mabel Smyth Auditorium on Friday, February 5 at 8:00 P.M. Dr. William S. Ito presided and approximately 100 members and guests attended.

Mr. J. Vevoda of Pfizer Laboratories discussed their recently developed product, intramuscular Terramycin.

Mr. Donald Billam-Walker of the Better Business Bureau described his organization's activities in connection with medicine, citing several examples of fraudulent practices now evident in the Territory.

The guest speaker for the evening was Dr. E. Kost Shelton, Clinical Professor of Medicine at the University of California at Los Angeles. Dr. Shelton discussed "The Modern Concepts of Clinical Endocrinology."

Following the scientific session, Dr. John Felix, Treasurer, presented the annual budget for 1954-1955. After a vigorous discussion the budget was amended and approved. Items of particular importance were: That dues be raised $10 per year ($85 to $95); that $500 be contributed to the support of the Oahu Health Council; that the Nursing Service Bureau receive $300 per year

(rather than $600) for services rendered; and that $1,500 be set aside for a postgraduate speaker with the stipulation that the fund not be used during 1954.

R. C. DURANT, M.D.
*Secretary.*

## KAUAI COUNTY MEDICAL SOCIETY

The regular meeting of the Kauai County Medical Society was held on November 10, 1953 at the G. N. Wilcox Memorial Hospital medical library. The meeting was called to order by Dr. Ishii, president, at 7:45 p.m. Members present were Drs. Kim, Cockett, Wallis, Goodhue, Masunaga, Wade, and Brennecke. Guest present was Dr. Rosengard, Chief of V. D., Cancer Control, and Chronic Diseases of the Territorial Board of Health.

It was moved and unanimously voted that the Society employ legal counsel and forward a communication to Dr. Maxwell Boyd bringing out the following points:

(1) It was due to an oversight of the Secretary that Dr. Boyd was erroneously informed that his application for membership had been accepted.

(2) Dues collected from him have been refunded.

(3) His application for membership had not been voted upon.

A motion to obtain Mr. Jack Mizuha as legal counsel was made. This was seconded and approved.

A dinner-meeting at the Kauai Inn on November 18, 1953, with Dr. Alvarez as guest speaker, was planned.

Dr. Rosengard, guest speaker, gave an interesting talk on "Diabetes."

A movie on prenatal care was viewed.

* * *

The regular meeting of the Kauai County Medical Society was held on December 8, 1953 at 7:30 p.m. in the Wilcox Memorial Hospital medical library. Meeting was called to order by Dr. Ishii. Others present were Drs. Kuhns, Fujii, Masunaga, Cockett, Wallis, Wade, Boyden, Ishii, Goodhue, and Yamauchi. Guests were Dr. A. Connor and Miss Summers.

Dr. Brennecke suggested that the members of the Society attempt to formulate some arrangement whereby the Bureau of Medical Economics of the Honolulu County Society will serve as a collecting agency for delinquent accounts in Kauai. A brief discussion followed but no definite action was taken.

Dr. A. Connor, one of the guest speakers, discussed the crude means test for determining the patients eligible to attend the Child Health Conference. Dr. Wallis made a motion to adopt such schedule as would be appropriate for the island of Kauai. This was seconded and was approved.

Miss Summers, psychiatric medical social worker for Kauai, gave a brief talk on the Mental Health Clinic which has been established recently on Kauai.

* * *

The regular meeting of the Kauai County Medical Society was held on January 12, 1954 at 7:45 P.M. in the G. N. Wilcox Memorial Hospital medical library. The meeting was called to order by Dr. Ishii. Members present were Drs. Kim, Kuhns, Wade, Masunaga, Wallis, Goodhue, Cockett, Brennecke, and Yamauchi. Guest was Dr. Pershing Lo.

Dr. Kim was appointed to represent the Society at the Kauai Health Council meetings.

A letter from Dr. Chung-Hoon was read regarding the acceptability of holding the 1956 centennial celebration in Honolulu instead of in Kauai and of electing a president-elect from Kauai. Dr. Wade moved that our delegate, Dr. Wallis, express the Society's approval of holding the 1956 centennial celebration in Honolulu and of electing the president-elect from Honolulu. Dr. Cockett second the motion. This was unanimously approved.

A letter from Dr. Connor was read regarding the application of the Honolulu Means Test for child health conferences here in Kauai. Dr. Wade made the motion to accept the scale used in Honolulu on a probationary basis with future adjustment to be made as necessary. This was seconded and approved.

Dr. Lo gave a talk on the function of the Kauai Mental Health Clinic.

RICHARD M. YAMAUCHI, M.D.
*Secretary*

## MAUI COUNTY MEDICAL SOCIETY

The regular meeting of the Maui County Medical Society was held on December 15, 1953 at the Central Maui Memorial Hospital. Those present were Doctors Tompkins, Ferkany, Cole, Ohata, St. Sure, Kashiwa, Haywood, Underwood, Izumi, Rockett, Fleming, McArthur, H. Kushi, Kanda, A. Y. Wong, Boyd and Mei.

A letter from Territorial president Chung-Hoon was read in regard to changing the 1956 annual meeting from Kauai to Honolulu. The Delegate was instructed to follow the wishes of the Kauai Society in regard to this matter.

The secretary notified the society that Dr. Wilkinson's membership has been transferred to the Honolulu County Medical Society.

Dr. McArthur discussed briefly the possibility of having some sort of Collection Agency on Maui participated in by the Society, similar in nature or in conjunction with the type now operating in Honolulu under the auspices of the Honolulu County Medical Society. It was moved by Dr. McArthur and seconded by Dr. Fleming to have the president appoint a committee known as the Economic Advisory Committee to look into this problem.

Application from Dr. Maxwell Boyd for membership in the Maui County Medical Society was received. It was referred to the Board of Governors for future consideration.

* * *

A special meeting of the Maui County Medical Society was held at the Central Maui Memorial Hospital at 7:30 p.m., January 5, 1954.

The application for membership to the Society by Dr. Willis Butler of Molokai was reviewed by the Board of Governors and recommended for membership. He was accepted.

The application of Dr. Maxwell Boyd was reviewed by the Board of Governors and the Board recommended that the application be deferred. However, after much discussion, it was moved and seconded that he be accepted as a member of the Society. A vote was taken and the Society rejected the application of Dr. Boyd for membership.

HAROLD S. KUSHI, M.D.
*Secretary*

# Notes and News

## PERSONALS

**Dr. L. Q. Pang** has been invited to speak on Allergy in Otolaryngology at the A.M.A. meeting in San Francisco, June 21 to 25.

**Dr. Walter Quisenberry** will deliver the annual James Ewing lecture on cancer this year before the New York Academy of Medicine on May 6. His subject will be Attacking Cancer in a Community. He will review advances made in cancer control in Hawaii during the past seven years, especially through early diagnosis.

**Dr. Laurence M. Wiig** was elected president of the Hawaii Cancer Society at its annual meeting held on January 29, 1954.

**Dr. Wilfred H. Kurashige** announces the opening of his office at 181 South Kukui Street for the practice of dermatology and syphilology. Dr. Kurashige received his medical degree from Northwestern University School of Medicine in 1939. He interned at the Cook County Hospital, Chicago, for two years. Following this, Dr. Kurashige practiced for three years in Kona and for seven years as plantation physician with the Hutchinson Sugar Company and Hawaiian Agricultural Company in Hawaii. Dr. Kurashige has recently returned from two years specialized training at New York University, the Bellevue Medical Center, and one additional year at the New York University Post Graduate Medical School. He is certified by the American Board of Dermatology and Syphilology. Dr. Kurashige is married and has two children.

**Dr. Dorothy S. Natsui,** of 1531 South Beretania Street, announces the association of **Dr. Pershing S. Lo** in the practice of psychiatry. Dr. Lo is a graduate of the University of Michigan, 1948. He interned at the Madison General Hospital, Madison, Wisconsin, for one year and was resident in psychiatry at the Kings County Hospital, Brooklyn, New York. Following this, he was associated with the Psychoanalytic Clinic at the Columbia College of Physicians and Surgeons, New York. He then served as a captain in the United States Air Force. After his release from the service, Dr. Lo was Assistant Chief at the Bureau of Mental Hygiene, Department of Health, Honolulu. Dr. Lo is married and has three children.

**Drs. Lester Yee** and **Frank S. Lee** recently returned from trips to the mainland.

**Dr. Abe Ng Kamsat** was elected President of the United Chinese Society.

**Dr. Milton Rodolfsky,** Clinical Director of the Territorial Hospital, was guest speaker at the Temple Emanuel Sisterhood.

**Dr. Ralph Cloward** addressed the Women's Society of Christian Service of the Kailua Community Methodist Church on the subject of his African safari.

**Dr. Richard N. Yamane** announces the removal of his office to 929 Keeaumoku Street.

**Dr. Stanley W. Bergreen** and **Dr. Leonard Miller** have joined the staff of the Territorial Hospital. Dr. Bergreen is a graduate of St. Louis University School of Medicine. He received his psychiatric training at St. Louis State Hospital, Palo Alto Veterans Administration Hospital and Washington School of Psychiatry. He served in the United States Air Force in a clinical capacity and also in the office of the Surgeon General on a research project. Dr. Miller received his medical degree from the University of Kansas. He interned at the Detroit Receiving Hospital. During the war, Dr. Miller served with the United States Navy. He is married and has one daughter.

**Dr. Robert Kimmich** returned from a meeting of the Fifth Mental Hospital Institute in Little Rock Arkansas. While on the mainland, Dr. Kimmich also visited various hospitals throughout the country.

**Dr. B. Allen Richardson** has recently returned from the mainland, where he became a Fellow of the American Academy of Orthopedic Surgeons. **Drs. Steele Stewart** and **J. Warren White** also belong to Academy.

**Dr. Philip Corboy** addressed a large audience at the Lincoln School on February 25 on the subject, "American Public Schools—The Keystone of Democracy."

**Dr. Garton Wall** of Ewa plantation has opened a branch office in Pearl City.

**Dr. M. L. Hanlon** announces the opening of his office in association with **Dr. C. K. Kobayashi** at the King Kalakaua Building, 1423 Kalakaua Avenue, with practice limited to pediatrics. Dr. Hanlon graduated from Northwestern University School of Medicine in 1947. He interned at The Queen's Hospital and served a two-year residency in pediatrics at Kauikeolani Children's Hospital. Following this, Dr. Hanlon was physician at Kohala Plantation. He served with the United States Army Medical Corps for one and one-half years. He is married and has one child.

## Kauai

**Dr. and Mrs. Jay Kuhns** began a tour of the Orient and Europe in March. They will return the early part of June.

The mystery of the frequent Honolulu trips taken by **Dr. Eichi Masunaga** has been solved. Our Eichi, whose accomplishments in paintings and metal work are well known, is quietly studying the art of sculpture.

**Dr. and Mrs. Sam Wallis** entertained **Dr. and Mrs. E. Kost Shelton,** clinical professor at the University of California at Los Angeles, during the latter's visit to Kauai. Dr. Shelton gave a lecture on Endocrinology to the G. N. Wilcox Memorial Hospital medical staff on February 4, 1954.

The E. R. Squibb film library has lost two films somewhere in Hawaii:

*Coarctation of the Aorta*

and

*Malnutrition in the Hospital Patient*

If you know of their whereabouts, please return to H. E. Petersen, Box 3558, Honolulu.

### Pacific Coast EENT Meet

**The Pacific Coast Oto-Ophthalmological Society will hold its annual meeting in Honolulu from April 25 to 29 this year. A president's reception and buffet has been scheduled for 5 p.m. at the Royal Hawaiian Hotel on Sunday, April 25. The scientific sessions will take place at the Waikiki Theater and in the Diamond Head Lounge of the Moana Hotel, beginning at 8 a.m. on April 26, 27 and 28. Governor Samuel Wilder King will address the opening session in the Waikiki Theater on April 26. The golf tournament at the Waialae Country Club will be held that day also. On April 29 at 9 a.m. a meeting will be held at Hale Mohalu, followed by a luncheon at Tripler Army Hospital. Afternoons will be free for sightseeing, visiting and other amusements.**

## NEWS

### Woman's Auxiliary Notes

The Annual Meeting of the Territorial Woman's Auxiliary will be held in Honolulu in May at the same time as the men are meeting. The Honolulu County Auxiliary will be our hostess and they are planning a good time for all.

The House of Delegates will meet on Thursday evening, May 13, after dessert and coffee at the home of Mrs. C. W. Burgess. All neighbor island members will be most welcome, and those not actually involved in the Delegates' meeting may play cards or visit.

On Friday, May 14, we will go to the Racquet Club at Kailua for a day of informal fun—tennis, swimming, sunning and chatting, with luncheon, and the annual business meeting. Transportation will be taken care of by the County members. Wives of neighbor island doctors will be guests of the Honolulu County Auxiliary.

Saturday night we will join with the men for the Annual Banquet at the Oahu Country Club. We hope you will begin your planning now, so that we may have a good turnout to compare notes on what has been going on and what has been accomplished by the County Auxiliaries this past year.

Sunday noon there will be lunch, bridge and canasta on the Hau Lanai of the Halekulani Hotel.

### W.M.A. Assembly

The World Medical Association announces its 8th General Assembly to be held in Rome, Italy from September 26 to October 2, 1954. Further information may be obtained from the World Medical Association, 345 East 46th Street, New York 17, New York.

### First C.M.A. European Tour

The California Medical Association announces its first Annual Grand Medical Tour of Europe from April 5 to May 5, 1954. This tour is to include France, England, Italy, Holland, Belgium, Germany, and Switzerland. Further information may be obtained from the California Medical Association, 450 Sutter Street, San Francisco 8, California.

### VIth International Cancer Congress

The VIth International Cancer Congress, organized by the International Union Against Cancer, will be held in Sao Paulo, Brazil, from July 23 to 29, 1954. Details are available at the office of the Medical Society.

### American Geriatrics Society

The 11th Annual Meeting of the American Geriatrics Society will be held at the Hotel Fairmont in San Francisco just preceding the meeting of the American Medical Association. The scientific sessions of the meeting will begin Thursday afternoon, June 17 and continue through Saturday morning, June 19.

Hotel reservations should be made through the San Francisco Convention and Visitors Bureau, 200 Civic Auditorium, San Francisco 2, California. Members should reserve accommodations immediately, stating time of arrival and departure date, because the hotels expect to be filled to capacity.

Dr. Laurance W. Kinsell, Highland Alameda County Hospital, 2701 Fourteenth Avenue, Oakland 6, California, is in charge of local arrangements for the meeting.

### Pan American Congress of Ophthalmology

The Third Interim Congress of the Pan American Association of Ophthalmology will be held in Sao Paulo, Brazil, June 17-21, 1954.

### National Board of Medical Examiners

The Honolulu Subsidiary Board of the National Board of Medical Examiners will hold oral examinations in Honolulu on June 15, 1954, if six or more candidates register for the examination, Part III.

Notification of intent to register should be filed with Dr. A. S. Price, Queen's Hospital, by April 15 (telephone—5-5981, extension 350).

# Clinical Results* with Banthine® Bromide

(Brand of Methantheline Bromide)

## 22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

| AUTHORS | No. of Patients | Chronic, Resistant to Other Therapy | TYPES OF ULCERS | | | | RELIEF OF SYMPTOMS (Chiefly Pain) | | | | Surgery or Complications[1] | Side Effects Requiring Discontinuance of Drug[2] | EVIDENCE OF HEALING | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Duodenal | Jejunal | Stomal | Gastric | Good | Fair | Poor | No Report | | | Complete | Moderate | None | No Report |
| Grimson, Lyons, Reeves | 100 | 100 | 93 | 7 | | | 80 | 11 | 4 | | 5 | | 47 | | 19 | 29 |
| Friedman | 15 | 15 | 14 | | | 1 | 5 | | 4 | 6[3] | | | 2 | | | 13 |
| Bechgaard, Nielsen, Bang, Gruelund, Tobiassen | 26 | 26 | 21 | | | 5 | 16 | 4 | 6 | | | | 8 | 6 | 12 | |
| McHardy, Browne, Edwards, Marek, Ward | 162 | | 162 | | | | 136 | 12 | 11 | | 3 | 1 | 14 | 9 | 7 | 129 |
| Segal, Friedman, Watson | 34 | 34 | 34[4] | | | | 14 | 13 | | | 7 | 2 | 5 | | 8 | 14 |
| Brown, Collins | 117 | 99 | 117 | | | | 97 | 7 | 8 | | 5 | 8 | 55 | 9 | 8 | 40 |
| Asher | 77 | | 65 | | 7 | 5 | 52 | 9 | 16 | | | 16 | | 9 | 21 | 47 |
| Rodriguez de la Vega, Reyes Diaz | 5 | 4 | 5 | | | | 4 | | 1 | | | | | 3 | 2 | |
| Winkelstein | 116 | 116 | 102 | 8 | | 6 | 102 | | 14 | | | | 53 | | 18 | 45 |
| Hall, Hornisher, Weeks | 18 | 18 | 18 | | | | 11 | | 1 | 6[5] | | | 18 | | | |
| Maier, Meili | 38 | 38 | 24 | | | 14[6] | 27 | 7 | 4[7] | | | | 10 | 2 | 5 | 21 |
| Meyer, Jarman | 25 | 18 | 25 | | | | 21 | | 4 | C | | | | | | 25 |
| Poth, Fromm | 37 | 37 | 37 | | | | 33 | 3 | 1 | | | | 33 | 3 | 1 | |
| Plummer, Burke, Williams | 41 | 41 | 41 | | | | 36 | | 5 | | | | 38 | | 3 | |
| McDonough, O'Neil | 104 | 100 | 104 | | | | 63 | 10 | 31 | | | 11 | 4 | | 11 | 89 |
| Broders | 60 | 60 | 58 | | 1 | 1 | 35 | 19 | 6 | | | | 10 | 1 | 49[8] | |
| Legerton, Texter, Ruffin | 11 | | 11 | | | | 11 | | | | | | | | | 11 |
| Holoubek, Holoubek, Langford | 76 | 69 | 76 | | | | 35 | 27 | 10 | | 4 | 10 | 26 | | 10 | 36 |
| Ogborn | 42 | | 39 | 2 | | 1 | 42[9] | | | | | | | | | 42 |
| Shaiken | 48 | 48 | 48 | | | | 33 | 10 | 3 | | 2 | | 33 | 10 | 3 | |
| Johnston | 145 | 145 | 145 | | | | 143 | | 2 | | | 2 | 143 | | 2 | |
| Rossett, Knox, Stephenson | 146 | | 141 | | | 5 | 146 | | | | | 4[10] | 53 | | | 93 |
| TOTALS | 1443 | 968 | 1380 | 17 | 8 | 38 | 1142 | 132 | 131 | 12 | 26 | 54 | 552 | 52 | 179 | 634 |
| PERCENTAGES | | 67.8 | 95.6 | 1.2 | 0.6 | 2.6 | 81.3 | 9.4 | 9.3 | | | 3.7 | 70.5 | 6.6 | 22.9 | |

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

G. D. Searle & Co.
P. O. Box 5110, Chicago 80, Illinois

# To Brighten the Diet...

*...to make days and nights more pleasant for the aged patient*

An appetite stimulant...mild euphoretic...appealing sedative at bedtime...a supplemental natural source of minerals, vitamins, and readily absorbable nutriments—these are some of the roles that wine can play in the daily diet of your aged or convalescent patient.

Few substances—natural or artificial—can offer the unique combination of qualities found in wine, the traditional beverage of moderation. Praised through the ages for its "tonic" effect, wine has been intensively studied since 1939 by American laboratory and clinical investigators. These modern tests have revealed the physiological basis for subjective theories of past years, and are now explaining the action and fate of wine and its components in the body.

Many of the important physiological properties of wine differ significantly from those of plain alcohol. Wine increases appetite and heightens olfactory acuity. It stimulates the flow of salivary juices. Buffered by its own natural salts and organic acids, it provides a mild, prolonged stimulation of gastric secretion. This same buffer effect makes the diuresis produced by wine a slow, moderate one.

Wine is also a ready and pleasant source of nutrient energy, and of absorbable iron and other essential minerals. The vasodilating action of wine aids toward improving circulation and increasing cardiac output.

A bit of sherry or light wine before meals, table wine with luncheon or dinner, or a glass of port at bedtime can add a welcome touch of interest and "elegance" to the daily routine of the convalescent and the elderly patient. The day seems shorter and brighter, and the night more pleasant and relaxed.

For a few cents a day your patients can have wines produced from the world's finest grape varieties, grown in an ideal climate and handled with consummate skill. Research information on wine is available upon request. Wine Advisory Board, San Francisco 3, California.

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAMS, *Executive Secretary*, Honolulu

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## NEED FOR EDUCATION STRESSED AT ECONOMIC SECURITY WORKSHOP

Many aspects of the economic security program were stressed at the workshop held December 7, 8 and 9 at the Hotel New Yorker, in New York, but two were emphasized over and over: the need for education throughout ANA membership on the program and the importance of public relations in accomplishing its aims.

Seventy-five representatives from 41 states and 3 territories, Hawaii, Puerto Rico and Alaska, attended the sessions at which Miss Shirley Titus, chairman of the ANA Special Committee on Employment Conditions, presided.

Those attending heard Dr. Mary Schauffler, professor emeritus of sociology, Western Reserve, and Dr. Theresa Wolfson, professor of economics, Brooklyn College, speak on the socio-economic aspects of economic security.

These speakers pointed out that changes in society and the structure of occupations have brought about a movement among many groups of workers for economic security. The growth of the functions of a professional organization to include collective bargaining is a natural one, they said. Collective bargaining is a democratic process and the stigma of words related to union activities should not prevent nurses from using the processes to improve their employment conditions, which have proven so helpful for others.

Professional women should foster education for the development of democratic personalities; recognize the necessity for education for democratic group action accepting the fact that an individual cannot do what a group can do; participate in community activities and recognize the necessity for political action.

Henry Distelhorst, public relations counsel, Illinois State Nurses' Association, pointed out that there is no professional program which needs the support of favorable opinion more than economic security. The public will accept the program when it learns that it will benefit them.

However, public acceptance requires the support of our own membership. Nurses must constantly be sold on the work of the program, how to use it and what their obligations are to it. This will form favorable internal public opinion, a prerequisite for favorable external public opinion.

Julius Manson, supervising mediator of the New York State Board of Mediation, urged nurses to act collectively through their professional organization to better their own working conditions, at the Wednesday morning session.

Such action must come from nurses, he said, because they are to a large extent excluded from the benefits of labor legislation in effect because many work for non-profit hospitals which are exempt.

Hospital management, however, can sit down voluntarily with nurses to discuss employment conditions; and since nurses as a profession have given up one of labor's most powerful weapons—the strike—hospitals should be willing to take part in such discussions.

In the small discussion groups on Monday participants emphasized the need to disseminate information such as that given in the workshop to

all members of ANA. ESP (Economic Security Program) as a protection for the nurse and as a responsibility of the group was discussed. Groups also reported on the progress and problems of ESP in the states represented.

On Tuesday, the small groups discussed case studies and then met in a general session to present conclusions to a panel made up of members of the ANA Committee on Employment Conditions and moderated by Mrs. Judith G. Whitaker. A number of the groups agreed that more information of the values and workings of ESP might have prevented difficult situations. The advantage of using SNA spokesmen in negotiations since they are removed from the local situation and carry with them the prestige of a larger, stronger group was emphasized.

Also brought out was the need for a flow of information from SNAs on economic security and to SNAs on local situations; the importance of protecting nurses active in the program, and the responsibility which the SNA must assume to see that nurses who become leaders in the program are aware of the risks involved.

Wednesday morning groups discussed the role of the board of directors in a state economic security program. General conclusions were: the board must be well informed itself and must in turn see that members are educated on the program; the executive secretary or person who administers the program must have adequate staff and funds to do a good job; it is the board's responsibility to implement the program and until an economic security program is functioning a special committee may be appointed to temporarily carry on the work.

State problems were discussed by homogeneous groups on Wednesday afternoon and the issue stressed most often was the need for a larger membership to make an economic security program effective. Concern was expressed over the marginal membership of ANA and it was felt that every effort should be made to establish a membership which will represent an overwhelming majority of those actively practicing nursing.

## A HISTORY OF PUBLIC HEALTH NURSING IN HAWAII*

### 1930-1939

To centralize nursing efforts and to maintain a qualified staff of public health nurses throughout the Territory, a Bureau of Public Health Nursing with a nurse director was created in 1930, but it was not until 1931 that the Legislature approved a separate budget. The same year, the policy of employing only nurses with public health training was established. During this decade, positions in the Bureau of Public Health Nursing increased from 34 to 63. Salaries were provided by Territorial and federal funds, Hawaiian Homes Commission, the Board of Child Welfare, and the Kauai Tuberculosis Association.

Palama Settlement, the Board of Health, and the University of Hawaii combined their efforts to offer the first academic year course in public health training in September 1931 and give local nurses required instruction in this field. The education director of Palama Settlement's nursing service directed the course. Students studied basic subjects in regular University classes and did field work under close supervision of health and welfare agencies in the city and county of Honolulu. This course was patterned after similar ones on the mainland. The same year, the Bureau of Public Health Nursing, had a director with a supervisor for each county, leading to the formation of a "supervisors' council" to bring about organization and close relationship between the staffs of Palama Settlement and the Board of Health.

In 1933, Queen's Hospital nursing students were given a two-month period of affiliation with the public health nursing agencies as part of their basic training. That year, the Board of Health approved minimum qualifications for public health nurses, paralleling those formulated by the National Organization of Public Health Nursing in 1931. Supervision of midwives was included as a public health nursing function in 1935.

The rapid expansion of the Board of Health program in 1936 and 1937 resulted in more nursing positions but made it difficult to obtain qualified nurses. At the close of this decade, 83 per cent of the nurses met the minimum qualifications of the National Organization for Public Health Nursing. Palama Settlement and the Bureau of Public Health Nursing had their own nursing directors. As the sugar and pineapple industries gradually realized the importance of "preventive" measures in the health of the people, they began to require public health training for their field nurses. In 1939, there were 25 nurses working among plantation people, some of whom spent part of each day in hospital work and the remainder in the field.

### 1940-1949

A study in 1941 showed that in the United States as a whole, only 16 per cent of all nurses reported they had received one or more years of

* By Esther M. Stubblefield, Public Health Nursing Supervisor, Bureau of Public Health Nursing, Department of Health, Territory of Hawaii. Continued from previous issue.

public health training while 66 per cent in Hawaii reported having had this basic training. The same year, the public health nurses annual census listed Hawaii in second place with 81.5 per cent of its nursing personnel having had formal education in public health.

The amalgamation of the two nurse agencies in Honolulu occurred gradually and by July 1, 1943, the final transfer of seven staff and two supervising Palama nurses to the Board of Health was completed. Meanwhile, the course in public health nursing at the University of Hawaii was being offered every year except for a period during the early part of World War II. Adjustments in program and field service have been made to meet mainland standards. The course was first accredited by the National Organization of Public Health Nursing in 1935, a status it has since maintained, except for 1943 when the course was not given.

The great increase in undergraduate nursing classes required changes in the public health nursing affiliation. With the closing of the Palama medical department and the opening of out-patient departments of Queen's and St. Francis Hospitals in 1947, the schools of nursing integrated public health teaching in their hospital and out-patient departments with some extension in the homes.

Though there has been a shortage of trained personnel from the pre-war through the post-war period, the minimum qualifications set up by the National Organization of Public Health Nursing have applied to all nurses desiring permanent appointments. Salaries and working conditions compare favorably with those on the mainland. Further demands of nursing services resulted with the expanded health program of the Board of Health between 1940 and 1949.

In 1946 Hawaii rated second with 73.8 per cent and third in 1947 with 79.3 per cent in the annual public health nurse census as recorded by the U. S. Public Health Service.

Following labor-management adjustment after World War II, the economic situation on most plantations necessitated elimination of services previously provided—among them free medical service—and many of the field nurse positions on the plantations are no longer maintained.

### 1950-

The 1953 review of field nursing services on plantations indicates that these nurses devote part of their time to dispensary and clinic work and the remainder to home visiting. Fifteen are employed—6 on Hawaii, 3 on Oahu, and 2 each on Maui, Kauai, and Molokai.

The Department of Health's Bureau of Public Health Nursing provides all the public health nursing service that is available in the Territory. Emphasis is placed on health guidance which includes prevention and control of dishes. Bedside care of the sick is done on a demonstration basis. The necessity for close cooperation among agencies is accepted and practiced more extensively than in the early days. With the wider scope of health program, public health nurses have a greater need for wider knowledge.

Today, there are 87 public health nursing positions in the Territorial Department of Health. The annual census of the U. S. Public Health Service shows that 87 per cent of the public health nurses in Hawaii have studied one or more years in an approved health program. This is tops for the country. The national average is 37 per cent.

## RECRUITMENT OF STUDENT NURSES

Since adequate nursing is an important element in the treatment of polio patients, the National Foundation for Infantile Paralysis is actively supporting the recruitment of nurses.

A March of Dimes grant of $47,690 will assist the Committee on Careers of the National League for Nursing, 2 Park Avenue, New York 16, to continue its national program of recruitment of students for schools of professional and practical nursing. This was announced jointly by Basil O'Connor, president of the National Foundation for Infantile Paralysis, and John H. Hayes, chairman of the Committee on Careers.

Since 1949, the National Foundation has provided financial assistance to the Committee on Careers, which is sponsored by national nursing, medical and hospital organizations along with other professional and business groups. The 1954 grant will underwrite the committee's field services program designed to help state and local committees in their effort to interest young people in nursing careers.

## DO YOU KNOW THAT

Your Counseling and Placement Service will collect your references and keep your professional biography on file for use when you seek a new job?

That your professional biography can be sent anywhere you desire for your use if you move to a state or country?

That this service is free to members of ANA?

That the Counseling and Placement Service has on file jobs in other countries and on other islands?

That when there are no local nurses to fill positions in the Territory, the Professional Counsel-

ing and Placement Service will notify all the state nurses' association counselors about the job and its condition of employment?

That your Counseling and Placement Service attempts to find the right nurse for the right job?

That your Territorial Counseling and Placement Service is at 510 South Beretania, Honolulu, telephone 68630?

If you are thinking of a change, get an appointment with the counselor at the above address.

## NURSES' ASSOCIATION COUNTY OF KAUAI

Newly elected officers for the term 1954-1956 are as follows:

| | |
|---|---|
| *First Vice President:* | Mrs. Miyoko Masunaga |
| *Secretary:* | Miss Josephine Cortezan |
| *Directors:* | Miss Thelma Hensley |
| | Mrs. Marian Wade |

Those holding office for another year are:

| | |
|---|---|
| *President:* | Miss Myrna Campbell |
| *Second Vice President:* | Mrs. Grace Furugen |
| *Treasurer:* | Mrs. Marian Kawate |
| *Directors:* | Miss Elizabeth Middleton |
| | Mrs. Clella Cockett |

## NURSES' ASSOCIATION DISTRICT OF OAHU

Newly elected officers for the term of 1954-1956 are as follows:

| | |
|---|---|
| *Acting President:* | Mrs. Ethel H. Brown |
| *Secretary:* | Miss Vivian Zane |
| *Directors:* | Mrs. Genevieve Fase |
| | Mrs. Gladys Leong |
| | Mrs. Betty Rodrigues |

Hold over officers are:

| | |
|---|---|
| *Second Vice President:* | Miss Audrey Booth |
| *Treasurer:* | Mrs. Helen Williams |
| *Directors:* | Miss Millicent Larson |
| | Mrs. Patience Martelon |
| | Mrs. Esther Stubblefield |

## H.M.S.A.

Did you know that membership in the Hawaii Medical Service Association (HMSA) is available through your District Nurses' Association? Call your District President for information or write to HMSA, 1154 Bishop Street, Honolulu.

## VISITORS

Miss Marion Kent, R.N., Associate Editor of the *American Journal of Nursing,* visited your headquarters' office in January. She says the Journal would like to have more material on nursing programs and activities in Hawaii.

Miss Virginia A. Turner, R.N., Editor of the *Nursing World* (formerly *The Trained Nurse and Hospital Review*), also visited in the Territory.

Miss Ruth Ingraham, Nurse Education-Supervisor from the Trust Terrritory, was here for a week attempting to recruit a nurse to work with her in nursing education in the Truk District. We will let you know in the next issue what happened!

## MARGARET JONES MEMORIAL FUND

The Margaret Jones Memorial Fund Committee, in cooperation with the Board of Directors of the Nurses' Association, Territory of Hawaii, Inc., has completed arrangements with the Bishop Trust Company to have them administer the fund as a trust fund at the direction of the committee. Any item of more than $500 must be approved by the Board.

Recently the last days of one of our nurses were relieved of financial burden by a gift from the fund. It is to be regretted that the need was not brought to the attention of the committee until the end was very near, otherwise she could have been saved much unnecessary financial strain.

It is hoped that nurses in similar circumstances as well as those who can be assisted over difficult periods by loans will contact the committee chairman or Miss Adam.

The old saying "Cast your bread upon the water, and it comes back cake" seems to apply in the use of the fund for a worthy cause. In the recent incident referred to, considerably more money was donated to the fund "in memoriam" than was paid out. Perhaps, like all of us, the fund grows with use.

Loans for purposes of advanced education can also be made from the fund.

Remember this fund has been developed by nurses and friends of nurses for the use of nurses. Application blanks may be obtained from Miss Adam at the Mabel Smyth Building.

MARJORIE ELLIOTT, R.N., *Chairman*

## FACTS ABOUT NURSING

Have the FACTS ABOUT NURSING at your fingertips. Order your 1953 edition now from the American Nurses' Association, 2 Park Avenue, New York 16, New York.

Five years have seen changes in hospital nursing—

29% more personnel are taking care of the hospitalized ill in the United States today than in 1948.

46% more non-professional nurses are employed in hospitals.

12% more professional nurses are employed in hospitals.

72% more part-time general duty nurses are employed in hospitals.
21% of the general duty nurses in hospitals today are working part-time.
20% more full-time instructors and head nurses are employed.
9% fewer private duty nurses are caring for hospital patients.

## NEW NURSING BOOKS IN THE MEDICAL LIBRARY

1. Donahue, Wilma and Tibbitts, Clark, *Planning the Older Years,* University of Michigan Press, Ann Arbor, 1950.
2. Donahue, Wilma and Tibbitts, Clark, *Growing in the Older Years,* University of Michigan Press, Ann Arbor, 1951.
3. Pillsbury, Mary E. and Sachs, Elizabeth J., *Nursing Care of Communicable Diseases,* 7th ed., J. B. Lippincott, Philadelphia, London, Montreal, 1952.
4. Frank, Sister Charles Marie, *The Historical Development of Nursing,* W. B. Saunders, Philadelphia, London, 1953.
5. Bower, Albert G. and Pilant, Edith B., *Communicable Diseases,* 7th ed., W. B. Saunders, Philadelphia, London, 1953.
6. Jensen, Deborah MacLurg, *Ward Administration,* The C. V. Mosby Company, St. Louis, 1952.
7. Cardew, Emily C., *Study Guide for Clinical Nursing,* J. B. Lippincott, Philadelphia, London, Montreal, 1953.
8. Sellew, Gladys and Pepper, Mary F., *Nursing of Children,* W. B. Saunders, Philadelphia, London, 1953.
9. Goodnow, R. N., *Nursing History,* 9th ed., W. B. Saunders, Philadelphia, London, 1953.
10. Muller, Gulli Lindh and Daives, Dorothy E., *Introduction to Medical Science,* 3rd ed., W B. Saunders, Philadelphia, London, 1953.

## HOW TO MAKE A LAW

The film "Wisconsin Makes Its Laws" has been chosen by the ANA Committee on Legislation as a blueprint on legislative procedure. The step by step process of law making is presented.

In preparation for the legislative session of 1955, the Nurses' Association, Territory of Hawaii, Inc., is attempting to borrow this film for May or June for use throughout the Territory. We think you will all want to see this. Your district will give you further news.

## 1954 ANA CONVENTION

CHICAGO, ILLINOIS
April 26-30

Theme: "Calling American Nurses to Action"
Headquarters: Conrad Hilton Hotel
Registration fee: $5 for members; $6 for non-members

Delegate representation is on the basis of one delegate from each NATH section (7) plus three delegates at large. Our big problem is funds to help pay delegates' expenses.

NOTE: Anyone attending the Biennial be sure to take your ANA membership card and be sure it is the proper section card.

## HUMAN RELATIONS INSTITUTE FOR ADMINISTRATORS

This institute was sponsored by the Oahu Health Council and the Society for Mental Hygiene. It was held at Camp Erdman from the evening of January 20 through noon of January 24. E. W. Haertig, M.D., psychiatrist from Seattle, Washington, was leader of the group.

At one of the first sessions Dr. Haertig pointed out that in the natural course of growth and development people are interested in themselves and their own affairs until around age thirty. They then become interested in the affairs of the community and the world about them. This should help us to understand the new graduates who are not interested in participating in nursing association activities and should guide our selection of committee members.

Nurses who attended the workshop are:

Mrs. Yvonne Walters, *Director of Nursing Service Bureau*
Miss Virginia Jones, *Director, University of Hawaii School of Nursing*
Miss Alison MacBride, *Chief, Public Health Nursing, Territorial Department of Health*
Mrs. Alice Scott, *Educational Director, Public Health Nursing, Territorial Department of Health*
Miss Bess Hammer, *Assistant Executive Secretary, Oahu Tuberculosis and Health Association*
Miss Claire Canfield, *Bureau of Mental Hygiene*
Miss Leona R. Adam, *Executive Secretary, Nurses' Association, Territory of Hawaii, Inc.*

## BOOK REVIEWS

*Nursing of Children.* By Gladys Sellew and Mary F. Pepper, 349 pp., Seventh edition, Price $3.75, W. B. Saunders Company, Philadelphia, 1953.

The new edition of Dr. Sellew's excellent text has been divided into two sections. The first part of the book has been rewritten by Miss Pepper. It is organized according to age-levels from birth to adolescence. In general the nursing care is treated as each group is attacked by the diseases common to the group. This section also includes the importance of a recreation and play program in the hospital.

All material in the book has been brought up to date. There are excellent references included. Many situation tests are also given on the more common diseases.

This book will be a valuable asset to any reference library. The average student will find it most acceptable reading. If used as a text, the instructor may have to supplement some of the brief paragraphs on some of the more common and important diseases of childhood.

SISTER MARIE THERESE.

*Nursing History.* By Minnie Goodnow, R. N., 440 pp., Ninth edition, Price $3.75, W. B. Saunders Company, Philadelphia, 1953.

This is a standard textbook (size 6 x 5) of 440 pages including the index at the end of the book and having a strong, durable, light blue cover with red letters for the title. The paper is smooth; the color an off white, almost cream, and the print bold and well-spaced, making it easy to read without worry of eye-strain.

The objective of the text is to "give nurses some idea of the development of their profession; it tries to help them visualize not only its past and the road by which it has come, but to present to them a vision of the future and to indicate their possible part in it."

Because it is divided into 15 chapters with subdivisions, the book makes for easier studying and reading from the student's point of view. Another contributing factor is the worth of the illustrations. Pictures from famous Museums and Collections are represented. A list of these 197 illustrations may be found in the front part of the text. Also of value to both teacher and student are the Important Dates, Summary and Reference Readings placed at the end of each chapter. The latter includes the latest articles from the Journals of Nursing, medical textbooks, noted histories and religious references.

*Nursing History* as the author and publishers present it can be considered reliable from many standpoints: Miss Goodnow carries out her objective to the end; the book is revised every four years; the style is one of simplicity and it is one of the few texts that contains any information about Nursing in Hawaii.

In the reviewer's opinion this book may be accepted as a teaching text.

SISTER MARY LAURINE.

## UNITED NATIONS DAY

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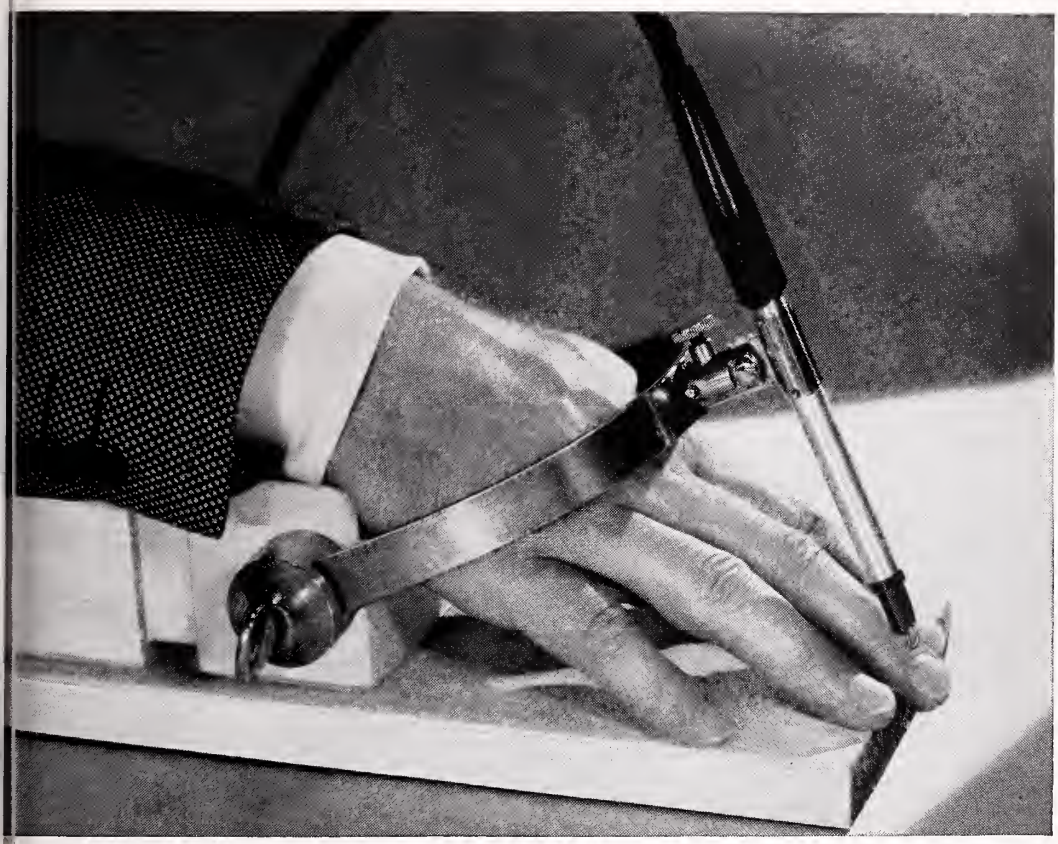
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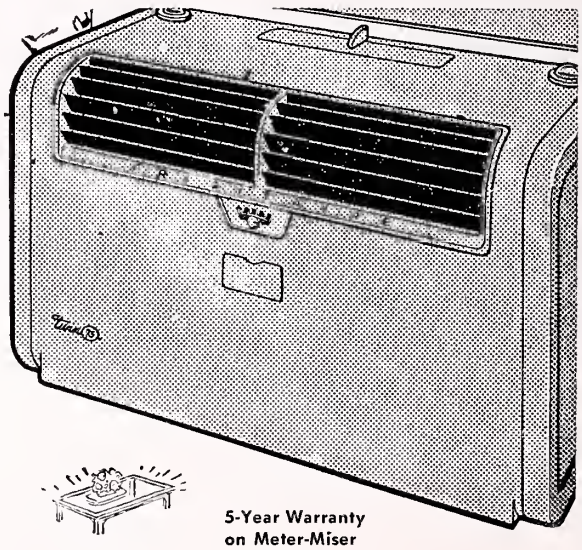
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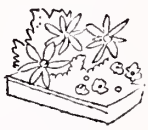
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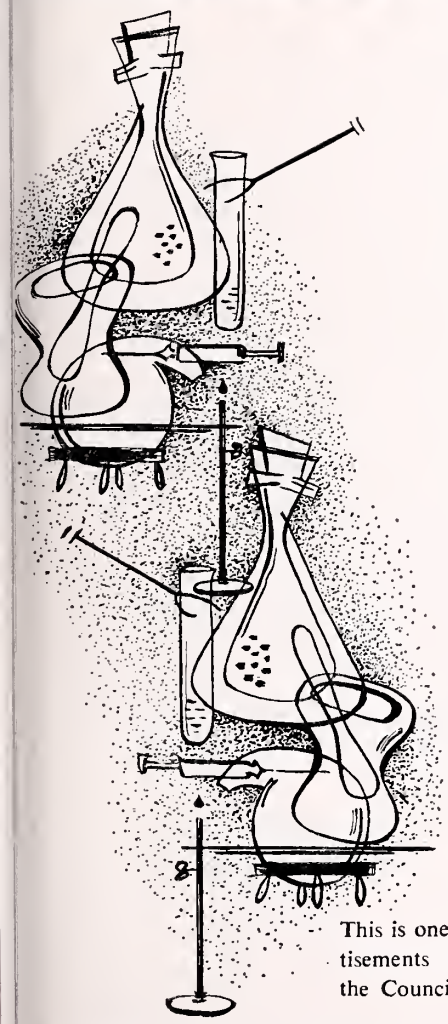
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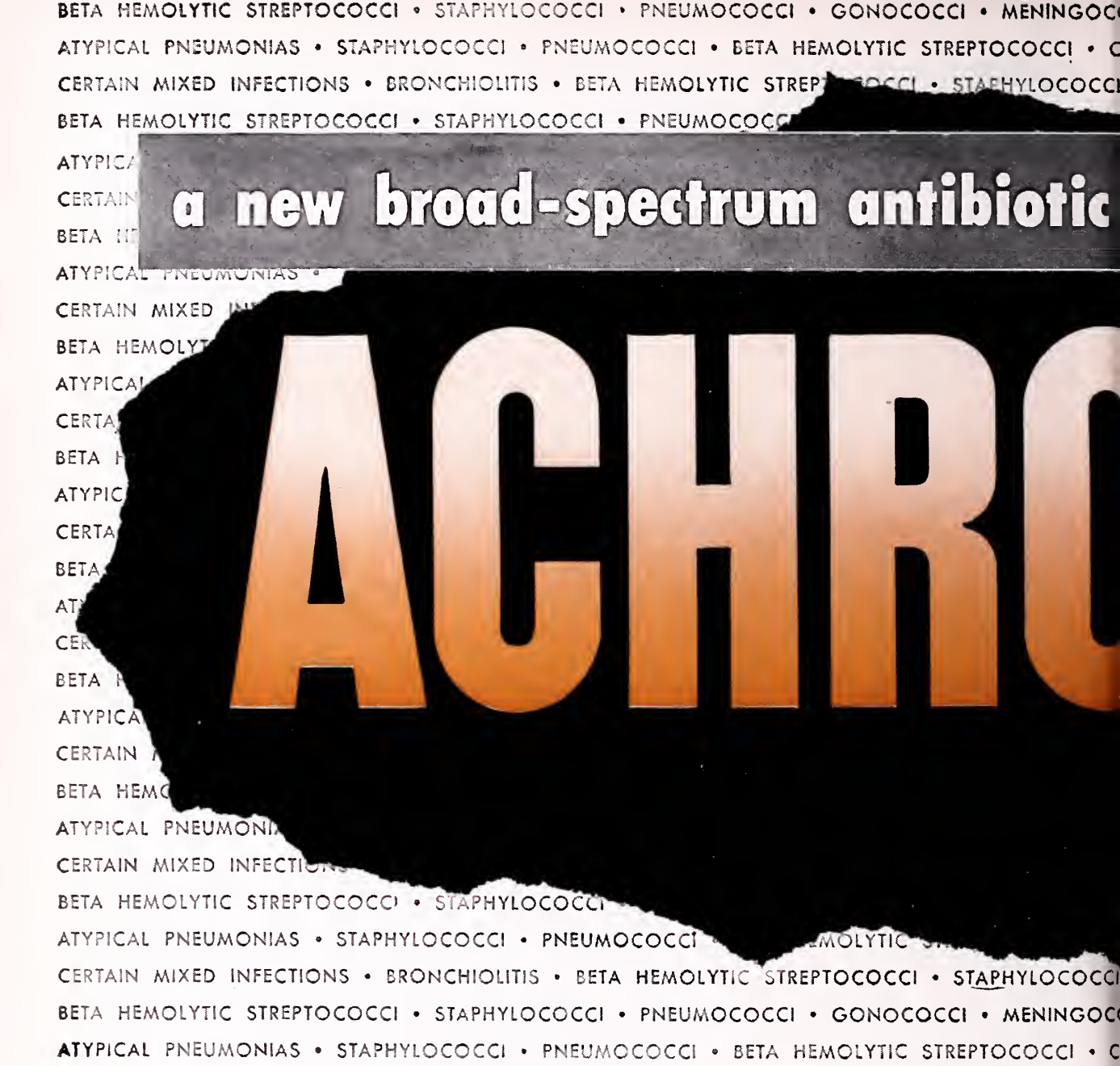
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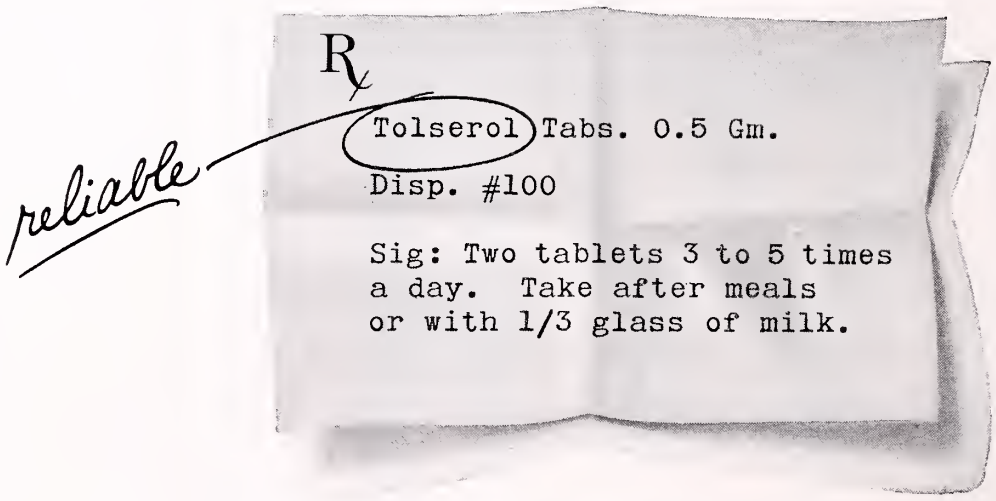

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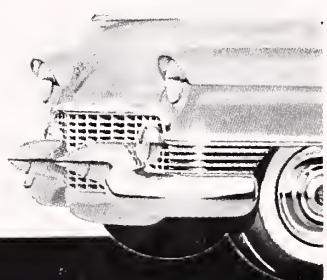
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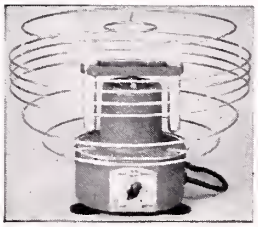
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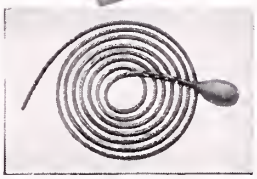
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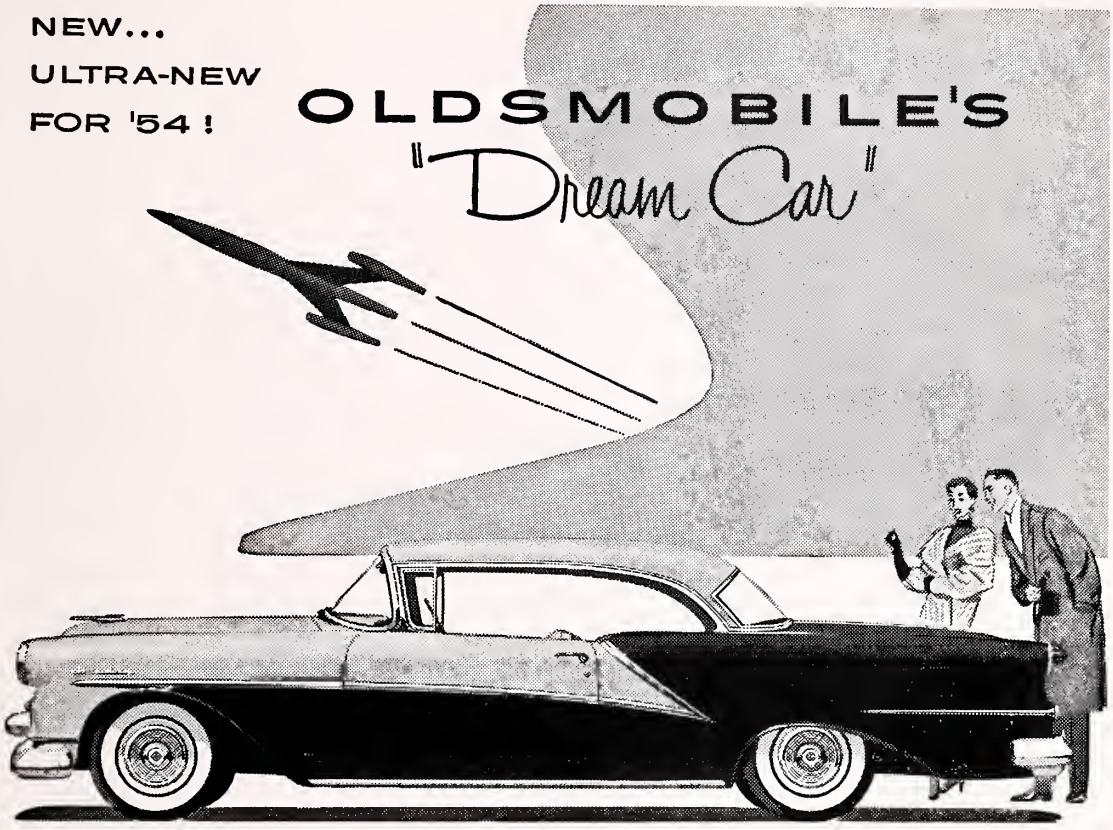
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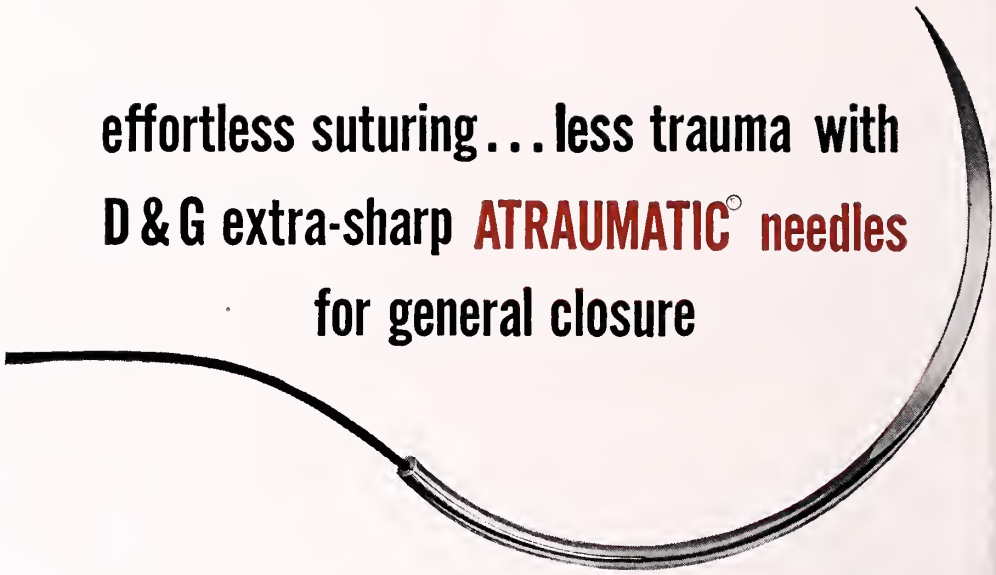
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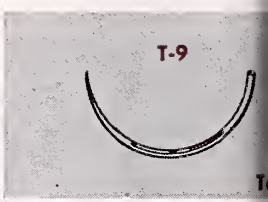


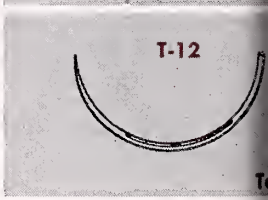
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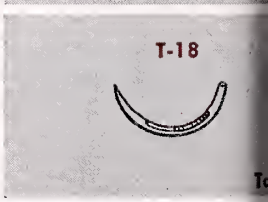
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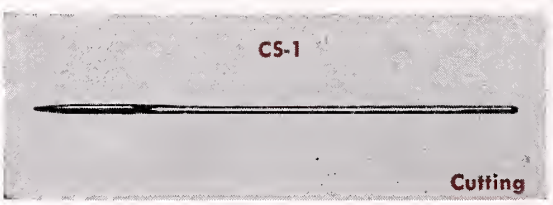
Study the needles illustrated here and ask your suture nurse for your selections. D & G Atraumatic needle-sutures simplify inventory and save nurses' time.

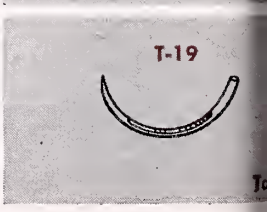
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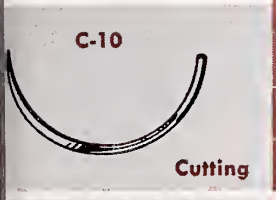
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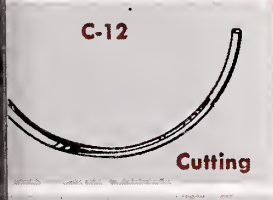
| No. | Type | Length | Needle | Sizes |
|---|---|---|---|---|
| 1509 | A, Plain | 27" | T-9 | 00 to 1 |
| 1546 | C, Med. Chromic | 27" | T-9 | 000 to 2 |
| 1508 | A, Plain | 27" | T-12 | 00 to 1 |
| 1548 | C, Med. Chromic | 27" | T-12 | 000 to 2 |
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| 693 | C, Med. Chromic | 27" | R-1 | 00 to 1 |
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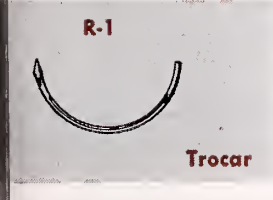
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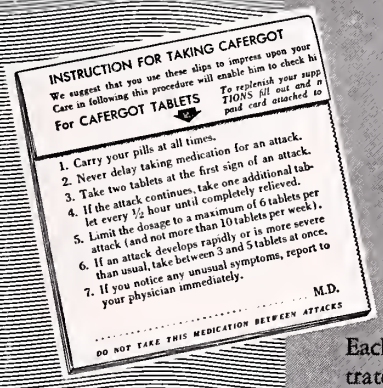
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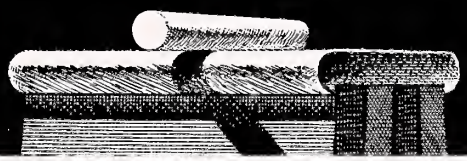



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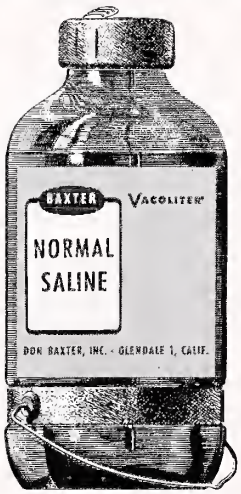


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1. English, A. R.; P'an, S. Y.; McBride, T. J.; Gardocki, J. F.; Van Halsema, G., and Wright, W. A.: Antibiotics Annual (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.
2. Finland, M.: Brit. M. J. 2:4846 (Nov. 21) 1953.

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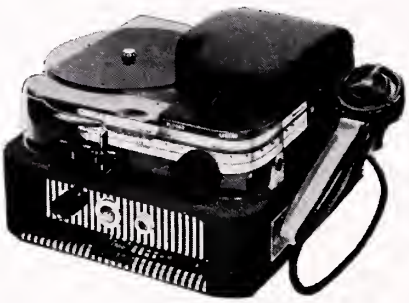
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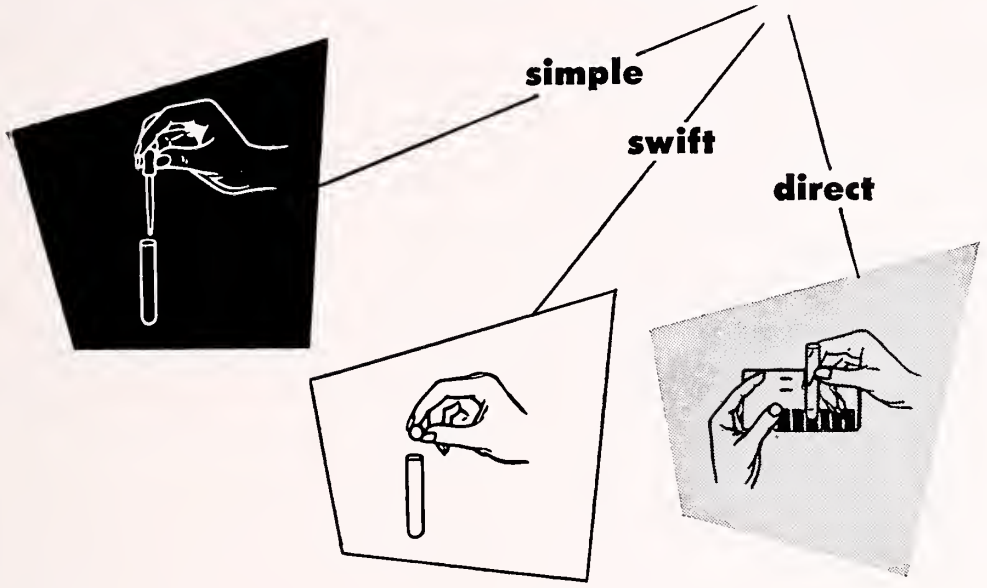
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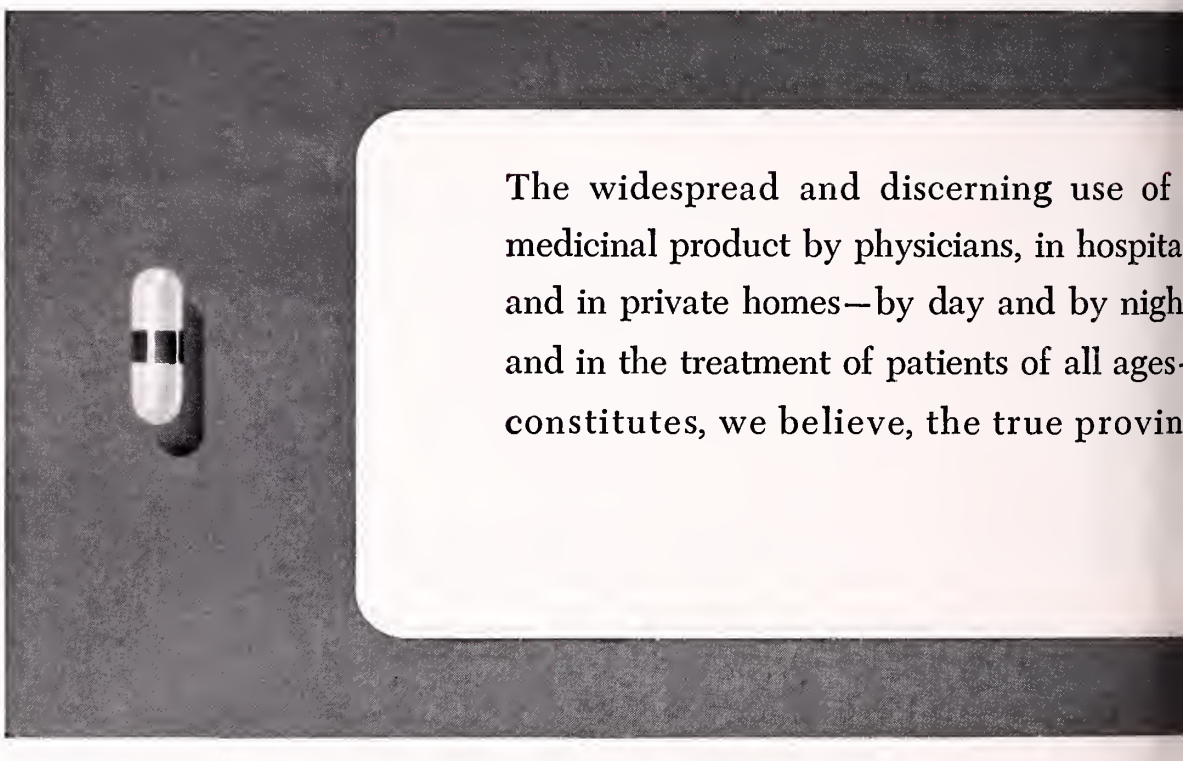
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MAY-JUNE, 1954

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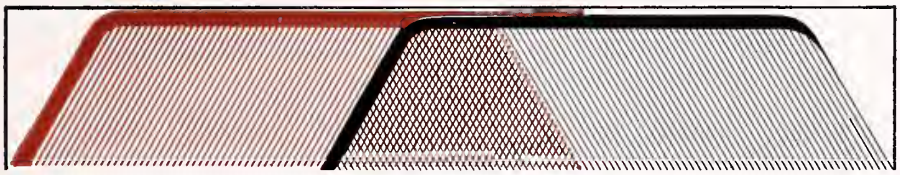
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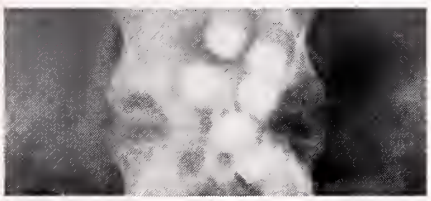
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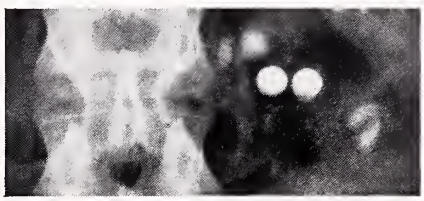
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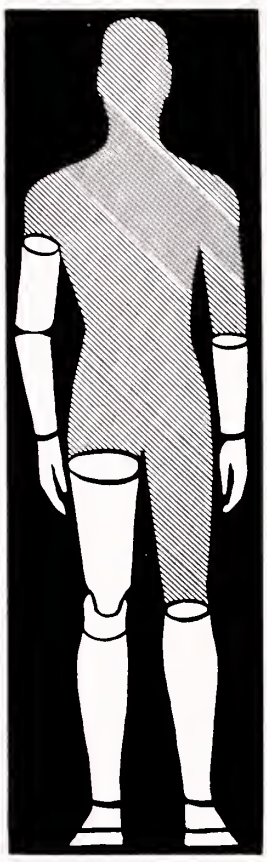
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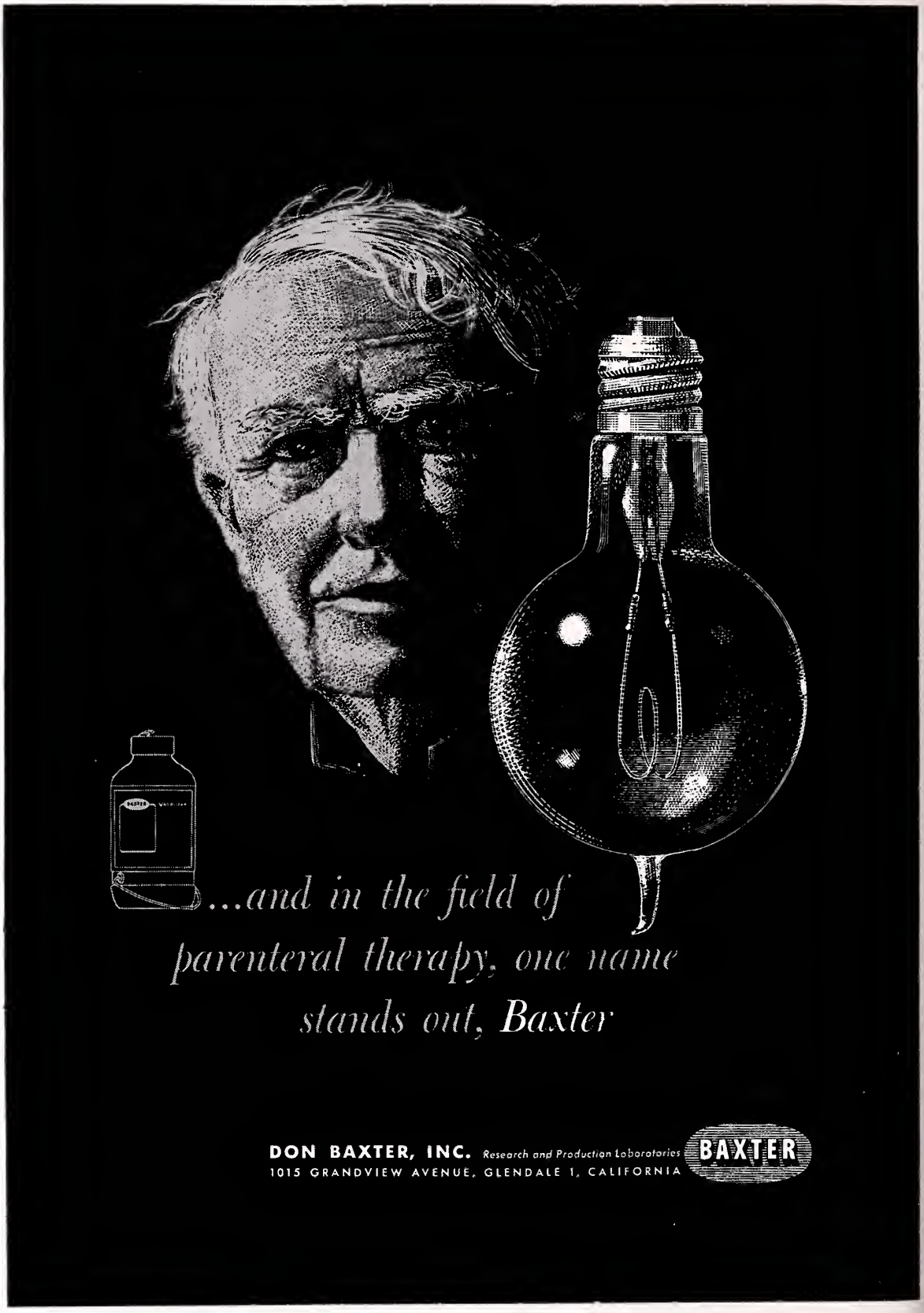
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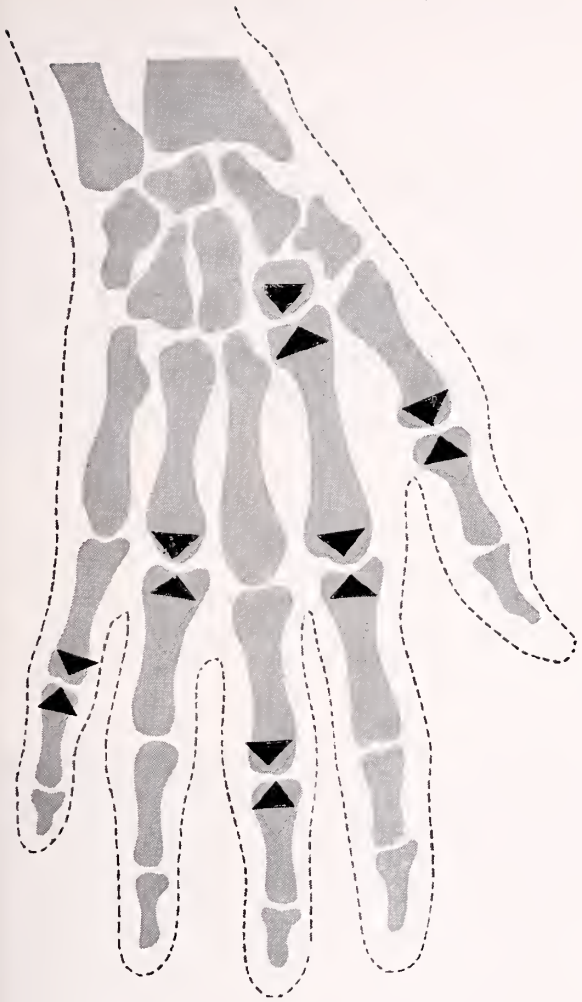
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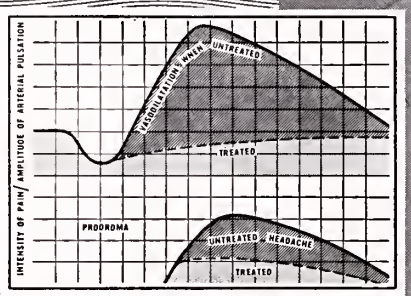
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Supplied: Bottles of 20 and 100 tablets.



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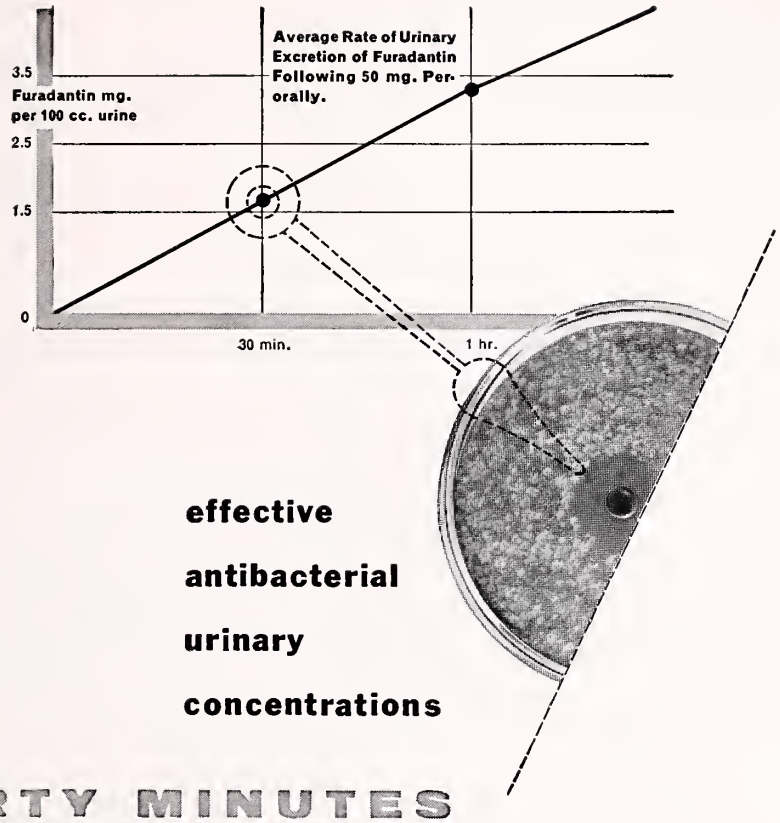
*(adapted from Wolff, H. G.: Headache and Other Head Pain, Oxford University Press, New York, 1948, p. 268.)

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**helps prevent hemorrhage,**

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**DOSE:** 1 or 2 tablets three to four times a day until the fourteenth day following delivery.

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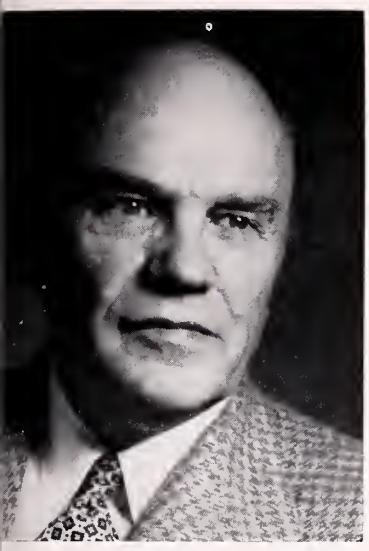
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NILS PAUL LARSEN, M.D.

# Our New President

Stockholm-born, never naturalized, 63 years young, Dr. "N.P." Larsen became President of the Hawaii Medical Association on May 14, 1954.

Dr. Larsen came to the United States before the turn of the century, and became a citizen by virtue of his father's naturalization. His interest in agriculture, which was to influence his medical interests in later years, resulted in his obtaining a B.Sc. from the Massachusetts Agricultural College in 1913. His medical degree from Cornell followed three years later.

After a distinguished career as a Major in the U.S. Army Medical Corps, including overseas duty, he came to Hawaii in 1919 to visit his brother. Three years later, having married the girl (Sara Lucas) who met him at the boat, he returned to Hawaii and became Pathologist, and subsequently Medical Director, at The Queen's Hospital, posts he held until his retirement from them in 1942.

During his tenure at Queen's he established the famous weekly Thursday Morning Clinics, vigorously conducted teaching sessions, generally better attended (the praise is undeservedly faint) than the meetings of the County Medical Society. The blood flowing from the discussants (figuratively speaking, of course) often created as much excitement as, or more than, that which had flowed from or in the patients.

In 1934, with Drs. James Judd, Arthur Molyneux, "Pete" Halford and R. L. Mansfield, Dr. Larsen became a founding member of the Medical Group, of which he is now the senior partner.

Dr. Larsen was secretary of the Honolulu County Medical Society in 1926, only four years after his arrival in the Territory, and became its President in1927 and again in 1945. He was continuously active in Society affairs for ten years after his first presidency and for three years after his second one. He was a Councillor of the Territorial Medical Association from 1934 to 1936.

In 1943 Dr. Larsen became Medical and Health Adviser to the Hawaii Sugar Planters' Association, an organization he had been advising for years in regard to a program of preventive medicine which contributed greatly to the general health of the Territory as a whole.

To completely catalogue the countless fields of activity of this extraordinarily energetic man would fill this issue of the JOURNAL all by itself. This summary, sketchy as it is, will have to do. We wish Dr. Larsen well in this post, and anticipate that he will fill it with distinction and with profit to the Association he has already served so long and so well.

# THE EPIDEMIOLOGY OF PARALYTIC POLIOMYELITIS IN HAWAII

JAMES R. ENRIGHT, M.D.,* Honolulu

POLIOMYELITIS, or infantile paralysis, was not a reportable disease in Hawaii until 1911. Prior to that, all deaths which could be attributed to polio were grouped under the heading "paralysis." In 1909[1] the Secretary of the Board of Health requested that physicians give the cause of the paralysis: whether agitans, infantile paralysis, etc. This is the first mention of the disease in official reports. Following this, deaths were still grouped under "paralysis" until 1911.[2] This report states that while there had been a few cases of poliomyelitis previous to 1900, there were so few that until 1910, the disease was not made reportable. Owing to a marked increase during November of this year "which threatened to become epidemic," this disease was added to the list of reportable diseases, and 36 cases were reported before July 1911, of which 16 were from Honolulu. There were 8 deaths attributed to polio, 6 in Honolulu and Rural Oahu and 2 in Hawaii. This would seem to indicate underreporting of cases, as deaths seldom exceed ten per cent of the number of cases.



DR. ENRIGHT

The Territorial Health Officer, J. T. Wayson[3], in 1927 reported:

> For some unaccountable reason, it has been quite evident that the physicians have, in the past, overlooked the fact that the foregoing disease is reportable.
>
> During the latter part of 1926 [it was known] that several cases of acute anterior poliomyelitis were under observation by physicians in Honolulu and on the Island of Maui, but that they had not officially reported the same; therefore, a campaign of publicity on the subject was issued which caused the physicians . . . to promptly report all recent cases. . . . There has never been an epidemic in Hawaii, but corrective work at the Shriners' Hospital proves that there has been a large number unreported. The medical officer in charge at the hospital personally stated to me that there were at least between four and five hundred children in the Territory who showed defects . . . due to poliomyelitis.

Lee's report[4] also brings out the fact that the Bureau of Crippled Children had a surplus number of cases under treatment for late effects of polio that were not registered with the then Bureau of Communicable Diseases. It must be pointed out that this discrepancy is not entirely due to underreporting by physicians. As will be shown, the attack rate in Hawaii is quite high in infants and pre-school children. Many of these patients were not seen by physicians until long after the acute stage, and were brought to the physician's attention for correction of late effects or were discovered at the time of examination for school entrance.

From the available information, it is permissible to state that poliomyelitis was present in Hawaii prior to 1911, and did not reach so-called epidemic proportions until 1939 and 1940. The rising incidence of the disease in the past fifteen years, the completeness of reporting as well as the changing health picture in Hawaii, and the close cooperation and cross-reporting between the Bureaus of Crippled Children and Epidemiology and the National Foundation for Infantile Paralysis, were considered to furnish sufficient data to warrant another study of the epidemiology of this disease.

## Method

The cases of paralytic poliomyelitis registered between January 1, 1938 and December 31, 1952 were hand-sorted for the accompanying data. All non-resident cases developing the disease outside the Territory were omitted. Racial descent and age at time of attack were checked when possible by the birth certificates on file in the Bureau of Health Statistics. All cases were placed in the month of onset of symptoms rather than in the month of registry. Cases by month of onset include civilians, resident military dependents and cases in the military forces. When attack and racial rates are given, military cases are omitted, as military personnel are not included in population figures. This study is confined to paralytic cases only, as "the diagnosis of cases which are not at sometime paralytic is so

* Chief, Bureau of Epidemiology, Department of Health.
Received for publication April 5, 1954.
[1] Report, President, Board of Health, Fiscal 1909, p. 108.
[2] Report, President, Board of Health, Fiscal 1911, p. 33.
[3] Report, President, Board of Health, Fiscal 1927, p. 90.
[4] Lee, R. K. C.: Public Health Reports 56:1556 (Aug. 1) 1946.

TABLE 1.—*Paralytic Polio Cases, Territory of Hawaii, 1938-1952 Inclusive—514 Cases. Corrected for Month of Onset. Off-shipping Excluded.*

| | JAN. | FEB. | MAR. | APR. | MAY | JUNE | JULY | AUG. | SEPT. | OCT. | NOV. | DEC. | TOTAL CASES | TOTAL DEATHS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1938 | .... | 5 | 1 | .... | .... | .... | .... | .... | .... | .... | .... | .... | 6 | 2 |
| 1939 | 1 | .... | 1 | 4 | 3 | 5 | 14 | 10 | 5 | 4 | 5 | 11 | 63 | 5 |
| 1940 | 7 | 8 | 3 | 6 | 12 | 7 | 5 | .... | .... | .... | 2 | .... | 50 | 5 |
| 1941 | 1 | .... | .... | .... | .... | 2 | 1 | .... | 11 | 9 | 8 | .... | 32 | 5 |
| 1942 | .... | .... | .... | .... | .... | .... | .... | 1 | 2 | 1 | .... | 1 | 5 | .... |
| 1943 | 1 | 4 | 14 | 29 | 15 | 11 | 1 | .... | 1 | 1 | .... | .... | 77 | .... |
| 1944 | .... | 1 | .... | .... | .... | .... | 1 | .... | 1 | .... | .... | .... | 3 | .... |
| 1945 | 2 | .... | .... | .... | .... | .... | 1 | .... | .... | .... | .... | .... | 3 | .... |
| 1946 | 3 | 2 | .... | 1 | .... | .... | .... | 1 | 1 | 2 | 2 | 3 | 15 | 2 |
| 1947 | 5 | 2 | 3 | 3 | .... | 15 | 3 | 2 | 3 | .... | .... | .... | 36 | .... |
| 1948 | .... | 1 | .... | .... | .... | .... | .... | .... | .... | .... | .... | 1 | 2 | .... |
| 1949 | .... | 4 | 8 | 1 | 1 | 2 | 1 | 1 | 1 | .... | .... | .... | 19 | 1 |
| 1950 | .... | 2 | 3 | 3 | 5 | 3 | 1 | .... | 6 | 5 | 1 | 2 | 31 | .... |
| 1951 | .... | 2 | .... | 1 | .... | .... | 3 | 3 | 5 | 2 | .... | .... | 16 | .... |
| 1952 | 2 | 7 | 15 | 9 | 13 | 44 | 33 | 11 | 5 | 6 | 7 | 4 | 156 | 15 |
| TOTAL | 22 | 38 | 48 | 57 | 49 | 89 | 64 | 29 | 41 | 30 | 25 | 22 | 514 | 35 |

frequently uncertain that only paralytic cases should be counted officially as poliomyelitis in comparing rates, due precautions being taken in the other cases."[5]

Nonparalytic cases were made reportable in June, 1953 and are kept separately. The writer is also indebted to the Bureau of Health Statistics for aid in calculating the various attack rates.

## Over-all Incidence

During the fifteen year period in question, a total of 514 cases of paralytic polio were registered as having developed in the Territory. Of these, 36 cases occurred in the military forces, leaving 478 cases for the civilian population. This is an over-all attack rate of 7.0 per 100,000 population per year. Lee's figures[4] for the nineteen year period 1922-1940 inclusive indicate an over-all attack rate of 4.7 per 100,000 per year. Because of the meager data available during the earlier years, the former low rate may be partly attributable to underreporting, but there appears to be evidence that the attack rate in Hawaii is increasing as improvement in sanitation habits lessens the chance of acquiring early immunity. In most tropical and sub-tropical countries, after the initial high incidence attending its introduction into a non-immune population, paralytic polio tends to be of low incidence and infantile in character. Burnet[6] states that poliomyelitis is the one infectious disease which has become more widespread and severe with rising standards of living in the western world.

## Seasonal Incidence

Table 1 shows the polio cases for the fifteen year period 1938-1952 arranged according to month of onset. With the exception of 1939 and 1941, it can be seen that there is a tendency for most of the cases to occur during the first half of the year. Fifty-nine per cent have occurred by the end of June and 71% by the end of July. In the mainland United States, the cumulative weekly percentage distribution of polio cases over 1948-1952 shows that on the average one-fourth of the cases are reported by the end of the thirty-third week (circa Aug. 20), half by the end of the thirty-sixth week (c. Sept. 10), and three-fourths by the end of the fortieth week (c. Oct. 8). Thus, most of the cases occur in a spread of seven weeks and the peak incidence may be over sixty times the low incidence during a bad year.

On the mainland, there is a tendency for the northern states to have a later season than the southern states; however, none have such an early season as Hawaii. The average for 1948-52 shows one-fourth of the cases in Hawaii by the seventeenth week (c. April 30), half by mid-year, and three-fourths by the thirty-second week, the latter occurring at the time the mainland is approaching its peak. The fifteen week spread indicates that the sharp peaking of the mainland does not usually occur in Hawaii. The case-death ratio shows great variation in Hawaii and indicates that the disease varies in severity. The reason for this is not known and it is useless to speculate whether it is due to the introduction of new polio strains or variation in immunity. However, it may be noted that the 1938-41 total closely resembles the 1952 total in the number of cases and case-death ratio.

The 1941 incidence is worthy of note. After a long period of quiescence, cases began to be reported in unusual numbers during September. The rate continued unusually high during October and November. Then came Pearl Harbor, and all the general instructions to "avoid polio" were violated. Schools were closed. Children mingled in unaccustomed groups, dragging their gas masks. People in general were overworked, worried (but not in panic), and lived and ate in poorly ventilated blacked-out dwellings. Food was sufficient but not of accustomed variety. Sanitation broke down in overcrowded, underventilated eating establishments. Dysentery and enteritis increased, and there was a tremendous influx of newcomers. In spite of these "violations," not a single polio case developed during the next eight months!

[5] A.P.H.A., The Control of Communicable Diseases, 6th ed. 1945, p. 90.

[6] Burnet, M.: Natural History of Infectious Diseases, Cambridge Press, 1953, p. 216.

TABLE 2.—*Paralytic Polio by Age Group and Racial Descent. 15 Years—1938-1952 Inclusive. Military and Off-shipping Excluded.*

| RACIAL DESCENT | AGE GROUPS *Under 1 yr.* | *1-4 yrs.* | *5-9 yrs.* | *10-14 yrs.* | *15-19 yrs.* | *20-24 yrs.* | *25+ yrs.* | TOTAL | RACIAL RATE PER 100 M | RACIAL TB DEATH RATE PER 100 M 1938-1947 | RACIAL TB DEATH RATE PER 100 M 1950-1952 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Caucasian | 15 | 78 | 46 | 21 | 12 | 16 | 37 | 225 | **12.5** | **13.2** | **7.8** |
| Part-Hawaiian | 9 | 55 | 6 | 7 | 4 | 3 | 1 | 85 | **9.3** | **50.4** | **11.1** |
| Japanese | 17 | 46 | 21 | 7 | 6 | 5 | 6 | 108 | **3.9** | **55.8** | **14.6** |
| Chinese | 3 | 8 | 3 | 2 | 1 | 1 | 1 | 19 | **3.8** | **71.3** | **18.7** |
| Filipino | 6 | 8 | 3 | .... | 1 | 2 | 1 | 21 | **2.3** | **116.0** | **28.6** |
| Hawaiian | .... | .... | 2 | .... | .... | .... | .... | 2 | **0.98** | **236.8** | **87.9** |
| Others | .... | 12 | 2 | 3 | .... | .... | 1 | 18 | 6.4 | | |
| TOTAL | 50 | 207 | 83 | 40 | 24 | 27 | 47 | 478 | 7.0 | | |
| AGE RATE per 100 M | **27.7** | **40.0** | **11.0** | **4.8** | **3.2** | **3.9** | **1.5** | | | | |

### Racial Distribution

Hawaii is unique in its comparative isolation, combined with a population of nearly half a million consisting of large groups with distinctly different racial backgrounds. There is no segregation, and all races freely mix in work, recreation, and housing areas. They all share the same schools, restaurants, movies and means of transportation. This means that the chances of acquiring the polio virus are equal for every racial group, and if any significantly different attack rate is observed between these groups, segregation will not be a factor. In the course of breaking down the attack rates, a significant difference was observed among the various racial groups. Lee[4] was the first to record this, but the difference in attack rates between the pure Hawaiian and the part-Hawaiian group was so striking that birth records were used to determine racial backgrounds and the two groups were separated. Any person whose father or mother has Hawaiian blood is classed as a part-Hawaiian. The former division of Asiatic-Hawaiian and Caucasian-Hawaiian is no longer calculated and is not used. People with mixed parentage take the racial group of the father, except that in Asiatic-Caucasian parentage, the Asiatic is given the preference. Koreans, Puerto Ricans, Negroes, Samoans, etc., are classified under "others," as well as a few mixtures whose parents' backgrounds were obscure. These constitute but a small fraction of the cases.

### The More TB the Less Polio

A negative correlation exists between polio attack rates and tuberculosis death rates. The latter rates were used because they reflect the racial tuberculosis attack rates, and by checking death certificates determination of the racial background was facilitated.

Table 2 shows the several races broken down into specific age groups and rates are given for both factors. Racial tuberculosis death rates are given for two periods, (1938-47 and 1950-52) to show that although there is a significant improvement in tuberculosis death rates, the same correlation exists; i.e., the lower the turberculosis death rate the higher the polio attack rate. To the extent that tuberculosis is a disease spread by intimate contact under poor living conditions, the same conditions may act to give infants early immunization against polio, according to Aycock[7]. The same negative correlation between polio attack rate and tuberculosis death rate holds in the mainland United States, where polio is less frequent in the South than in the North, less frequent in the Indian than in the Negro, and most frequent in the Caucasian. The tuberculosis death rate is just the opposite—lowest in the Caucasian and in the North, and highest in the Indian and in the South.

### Age Distribution

Table 2 also indicates that over 70% of cases are under 10 years of age. The rate under 1 year is quite high as compared to mainland rates, and during an epidemic, such as occurred in 1952, the rate among children under 1 year may exceed 100 per 100,000. This is contrary to the experience on the mainland, where the rate under 1 year is comparatively low. The attack rate in Hawaii for 1952 in children under 1 year was 136 per 100,000. Seven of the cases were under 6 months of age and 12 were from 6 months to 1 year. McConnel[8] states that none under 6 months were recorded in British literature since 1918, but describes 10 paralytic cases in this age group out of 243 under his care in Belfast during the epidemic year of 1950. Hawaii's total of 156 cases in 1952 includes 142 civilian and 14 military cases.

### Effect of "Shots"

Statistical evidence has accumulated that there is a connection between immunization procedures and localization of paralyses from polio, although the quantitative importance is not great.

In March 1952, a conference was held by the U. S. Public Health Service at the request of the

[7] Aycock, L., Personal communication.

[8] McConnel, A. A.: Bulletin of Hygiene 27:823 (Sept.) 1952 (abstr.).

State and Territorial Health officers in regard to the subject. A statement was issued which read in part: ". . . Furthermore, poliomyelitis is at all times so rare in infants under 6 months of age . . . that it is advisable to continue immunization procedures for this age group even during poliomyelitis epidemics."

This is not true for Hawaii. The attack rate here is so high in children under 1 year that it is considered advisable to recommend withholding basic immunization in infants during the time polio is in epidemic proportions, and in the absence of a high incidence of the immunizable disease in question.

### Effect of Tonsillectomy

Prior to 1950, no attempt was made to correlate tonsillectomies and paralytic polio. Since then, the following possible correlations have been recorded:

TONSILLECTOMIES

1. 4 year female Caucasian. T & A. 6 weeks prior to onset. Performed on the mainland. Bulbar polio 7/9/52. Expired 7/17/52.
2. 4 year female part-Hawaiian. T & A. 5/15/52. Bulbo-spinal polio 7/10/52.
3. 4 year male Filipino. T & A. 6/23/53. Bulbo-spinal with quadriplegia 6/25/53.
4. 6 year male Caucasian. T & A. 12/18/53. Bulbar polio 12/31/53. Sister with symptoms of nonparalytic polio.
5. 6 year male Caucasian. T & A. 12/28/53. Bulbar polio 1/4/54.

IMMUNIZATIONS

1. 18 month female Caucasian. DPT right buttock 3/13/50. Paralysis of right leg 3/15/50.
2. 10 month female Caucasian. Off-shipping case. Developed paralysis of left leg in April 1950. History of immunization at time of paralyses. Type and site unknown.
3. 7 month male Japanese. DPT left deltoid 9/9/50. Paralysis of left upper arm on 9/29/50.
4. 8 month male Japanese. Typhoid imm. 2/20/52 and 3/4/52. Sites unknown. Bulbo-spinal polio involving left arm and leg 3/11/52.
5. 2 year male Caucasian. Tetanus injection 5/10/52. Bulbar polio 5/20/52. Expired 5/27/52.
6. 5 year male Caucasian. Typhoid imm. May 1952. Bulbar polio 7/1/52.
7. 7 month male Japanese. DPT left buttock June 1952. Flaccid paralysis right leg 7/5/52.
8. 6 year female Caucasian. DPT 6/13/52 right arm. Bulbar polio 7/9/52.
9. 4 month male Japanese. DPT 2 months prior to onset. Paralysis left quadriceps 7/6/52.
10. 1½ year female part-Hawaiian. DPT right arm 7/18/52. Flaccid paralysis right deltoid 7/21/52.
11. 7 month male Filipino. DPT June 1952. Paralysis both legs 7/23/52.
12. 5 month female Japanese. DPT left arm, smallpox vaccine right arm on 7/21/52. Paralysis of right arm and left hip 7/27/52.
13. 7 year male part-Hawaiian. DPT booster, left deltoid 7/16/52. Symptoms of polio developed same day resulting in an extensive flaccid paralysis of the left arm.
14. 9 months female Japanese. Typhoid 8/18/52, 8/23/52 and 9/1/52. Bulbar polio 10/10/52.

OTHER INJECTIONS

1. 18 year female Caucasian. Penicillin 10/10/50. Developed symptoms on 10/16/50 resulting in right hemiplegia and paralysis of left arm.
2. 18 month male Caucasian. Received immune globulin (measles contact) on 3/31/52. Paralysis of both legs 4/6/52.
3. 1 year male Japanese. Combiotic in left hip 6/8/53. Onset of symptoms 6/11/53 resulting in paralysis of left hip.
4. 9 year male Caucasian. Gamma globulin given 1/12/53 (polio contact). Developed symptoms 2/3/53 with heavy involvement of both legs. 2 year old brother also developed paralysis of both legs on same day. Lighter case. Received no gamma globulin.
5. 39 year male Caucasian. Received gamma globulin 2/22/54 (polio contact). Developed symptoms 2/26/54 and was hospitalized 3/3/54 with bulbar polio.
6. 9 month male Japanese. Onset of symptoms 3/8/54. Received combiotic in left leg 3/10/54. Paralysis of left leg developed 3/11/54.

Penicillin injections are not considered to favor the development of paralytic polio. The above case (No. 1 under "Other injections") was included because it was given prior to the development of symptoms.

### Military vs. Civilian Incidence

Prior to 1948, military dependents did not constitute a large proportion of cases, and a breakdown prior to that time would be unreliable as no attempt was made to separate them at the time. However, 18 of the 21 cases recorded in 1948 and 1949 were among military dependents. Of the other 3 civilians, 2 lived on Hawaii and 1 in Honolulu. Since that time, records have been kept and a separation is possible. The average length of residence of the military dependents was 13 months and the writer considered it of interest to see if there was any difference in the age breakdown between military dependents and other civilians, as the majority of the other civilians were born in Hawaii, or had lived here for a considerably longer period.

TABLE 3.—*Paralytic Polio. Non-Military and Military Dependents, Off-shipping and Military Personnel Excluded.*

| AGE, YEARS | JANUARY 1, 1948—MARCH 31, 1954 | | | 1938-1952 INCLUSIVE |
|---|---|---|---|---|
| | *Non-military civilians* | | *Military dependents* | |
| | *Cases* | *Per cent* | *Cases and Per cent* | *All civilians Annual attack rate per 100 M* |
| Under 1 | 31 | 15.5 | 11 | 27.7 |
| 1 | 30 | 15.0 | 11 | 52.5 |
| 2 | 26 | 13.0 | 9 | 42.5 |
| 3 | 23 | 11.5 | 10 | 40.1 |
| 4 | 12 | 6.0 | 9 | 25.5 |
| 5 | 14 | 7.0 | 5 | 17.8 |
| 6 | 4 | 2.0 | 9 | 11.9 |
| 7 | 12 | 6.0 | 4 | 13.2 |
| 8 | 5 | 2.5 | 1 | 7.3 |
| 9 | 1 | 0.5 | 3 | 4.0 |
| 10-14 | 8 | 4.0 | 1 | 4.8 |
| 15-19 | 9 | 4.5 | 1 | 3.2 |
| 20-24 | 8 | 4.0 | 8 | 3.9 |
| 25-34 | 10 | 5.0 | 16 | 1.5 |
| 35 & over | 7 | 3.5 | 2 | |
| TOTAL | 200 | 100.0 | 100 | 7.0 |

Accordingly, all cases registered between January 1948 and March 31, 1954 were separated into military dependents and non-military residents, omitting military and off-shipping cases. By chance, this happened to total 300 cases, of which 200 were non-military and 100 military dependents. The writer wishes to stress this entirely accidental result to emphasize the fact that no selection other than time of registry is involved. The results are given in Table 3. Percentages rather than rates are given for obvious reasons, but it can safely be stated that the 100 cases among military dependents represent a far higher attack rate than do the 200 cases in the non-military civilian population.

At the time this paper was prepared, corrected population figures specific for age and race were not available for 1953 and 1954, and cases occurring during these years were not included in the totals. A rough estimation shows little significant difference in these categories, except in the under-

one-year age group, which has a somewhat higher percentage of cases. During 1953 there were 38 civilian paralytic polio cases, giving an annual rate of 8.0 per 100,000. During the first quarter of 1954, there were registered 42 civilian cases, for an annual rate of approximately 35 per 100,000.

The percentages are broken down in single years under 10 to show the high incidence in early life as well as the sudden drop shortly after school age.

It was expected that the military civilians would reflect the age distribution commonly found on the mainland U.S., but it can be seen to approximate the distribution which has been experienced by the non-military, except for the high percentage in the 25-34-year group. The military dependent population at risk is constantly changing, as their average length of residence in Hawaii is less than three years, and while the over-all attack rate is high, the number of cases involved is probably not sufficient to demonstrate any significant departure from the appended 1938-1952 attack rate. It is permissible to state, however, that the number of cases in the first three grades of school would not serve to give significant results in a polio vaccination evaluation. It is also apparent that children of school age constitute only a small proportion of cases in both the military and non-military categories, and such procedures as closing schools, swimming pools and theatres, or giving mass gamma globulin prophylaxis to school children would not be effective in controlling an epidemic in Hawaii. Since children of 7 years and under constitute over 67% of polio cases, it is considered prudent to delay both basic and booster immunizations during any season of high incidence. As a rule, however, the polio season is over by the time school opens, which is not the case in the mainland U.S.

TABLE 4.—*Paralytic Poliomyelitis, 1938-1952 Inclusive. Attack Rates by Islands, Military Cases Excluded.*

| ISLAND | NUMBER OF CASES | ANNUAL ATTACK RATE PER 100 M |
|---|---|---|
| Oahu | 386 | 8.5 |
| Hawaii | 57 | 5.6 |
| Maui | 22 | 3.5 |
| Kauai | 12 | 2.6 |
| Molokai | 1 | 1.3 |
| TOTAL | 478 | 7.0 |

### Island Distribution

Table 4 shows the breakdown and annual rates according to island. No cases have ever been reported from Niihau (pop. c. 200), which is almost completely isolated. One child developed polio on Lanai (pop. 2,452 as of Dec. 31, 1953) in February, 1954, approximately nine days after returning from a trip to Honolulu. There have been no secondary cases on Lanai up to April 1, 1954. It can be seen that over 80% of the cases have been on Oahu, which also has the highest attack rate. One other case developed on Molokai during 1953. The development of these cases during years of low as well as high incidence, together with the comparatively small percentage differences between months of high and low incidence appears to indicate that the polio virus is widely disseminated in the Territory and is probably present at all times.

### Conclusions

1. Paralytic poliomyelitis has a low attack rate in the Territory, even during epidemics, as compared to mainland U. S.
2. It has a higher attack rate in the pre-school group, a comparatively high rate in children under 1 year of age, and a low attack rate in the school age group, both in the military dependents and other civilians.
3. The attack rate in military dependents has been considerably higher than in other civilians during the past six years.
4. There is a significant difference in the racial attack rates. They are high in the Caucasian and part-Hawaiian, intermediate in the Chinese and Japanese, and low in the Filipino and Hawaiian.
5. There is a striking negative correlation between polio attack rates and tuberculosis death rates among the several racial groups.
6. Because of the high attack rates in children under 7 years of age, the withholding of basic and booster immunizations during times of high polio incidence is indicated in Hawaii, both in the military dependents and other civilians.
7. Because of the consistently low attack rates in children between 8 and 19 years of age, the closing of schools, theatres and swimming pools, as well as the giving of mass gamma globulin prophylaxis to school children, are not warranted for the purpose of controlling a polio epidemic in Hawaii.
8. Over 80% of polio cases occurred on Oahu since 1938.
9. The trend of poliomyelitis during the past ten years has substantiated Lee's conclusion[4] in 1941—that polio in the Territory of Hawaii is definitely a public health problem, and with increasing migration to Hawaii its attack rate is likely to increase.

# POLIOMYELITIS

## Navy Cases on Oahu in 1953

CAPTAIN RICHARD H. FLETCHER, M.C., U.S.N., Honolulu

THE health of the Navy Department personnel and their dependents is influenced by the prevalence of disease in the area in which they are residing. This is particularly true for those diseases for which no immunization or prophylactic procedure has been developed. Poliomyelitis is one disease, in this category, that looms large in view of our recent experience in this area.



CAPT. FLETCHER

During the calendar year 1951, 16 diagnosed cases of polio, of which 13 were admitted to Tripler Army Hospital, occurred in this group. In 1952, 65 cases were admitted, of which 49 were Navy dependent personnel. In the calendar year of 1953, 26 poliomyelitis cases were admitted. Of these, 15 were Navy Department personnel and their dependents.*

This total figure of 15 for the calendar year would not have been so alarming, had the total experience been spread throughout the year. However, 11 of the 15 cases developed during the months of November and December and were confined to naval housing areas adjacent to Pearl Harbor and Barber's Point. This provided an attack rate significantly higher than that being experienced by either of the other military services or by the civilian group resident on Oahu during the same period of time. The further fact that it was limited to personnel resident in a rather restricted area, located on the leeward side of the Island, raised some interesting questions:

1. Why was the attack rate among Navy Department personnel and dependents different from that among other military services or civilians?
2. What factor was operating within these housing areas to provide a significantly higher rate of attack than in other areas adjacent?
3. What control procedures or measures might control the epidemic spread?

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The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

* Throughout this discussion, Navy Department personnel and their dependents will include Navy and Marine personnel and their dependents as contrasted to Air Force and Army personnel.

Relative to the first question, "Why a higher rate among Navy personnel than in their sister services and the civilian population?" The Navy has a shorter period of duty on Oahu than do either of the other services. Therefore, it is possible that we are introducing susceptibles into the area at a greater rate than either of the other services. In addition, the Army and Air Force recruit many of their personnel from the territory, and consequently may have a better immunized group to begin with. Further, it may be conjectured that there is a different strain of polio virus prevalent here than operates in most areas of the mainland, and consequently, the naval personnel have not become immunized to it. This might account for the low rate among the civilian population experienced during this same interval of time.

The type of poliomyelitis being experienced on Oahu had not yet been determined. Specimens were submitted on 2 cases to Dr. Paul's laboratory at Yale University for identification of the type. Both of these specimens proved to be type I Brunhilde strain of poliomyelitis. While this strain of poliomyelitis accounts for most of the paralytic cases observed on the mainland, it is not the only strain prevalent in some epidemics. Further studies are indicated to determine whether this is the usually prevalent type on Oahu, in civilian poliomyelitis, as well as the Navy's sister services. If such should prove to be the case, part of the explanation above would have been established. Additional specimens are being submitted on other cases admitted recently to determine if type I Brunhilde is the only strain being experienced in the present epidemic. In addition, serological study of titer of antibodies is being made.

An attempt to answer the second question was made by investigating all possible vectors or routes of spread in the housing areas involved. This investigation encompassed water supply, sewage disposal, milk supply, source of food procurement, etc. No common source was found for any appreciable number of cases. As the epidemic progressed it became apparent that the usual intimate contact type of spread was being uncovered more and more frequently.

Therefore, to our third question, "What measure or procedures could be established to control the further spread of the disease among this rather select group of the population?" First, the cases were isolated and all family contacts were given

gamma globulin. An effort was made to determine all intimate contacts, other than the family, who should be provided with gamma globulin. Restrictions on the activity of family and other intimate contacts were recommended. Information on the nature of the disease and the method of spread was prepared and distributed to all navy personnel and their dependents in the Fourteenth Naval District. This information contained certain recommendations for action by the family members in order to preserve their health and avoid contact with possible sources of disease.

That the above recommended procedures were not adequate was indicated by the appearance, in the first eight days of January, of 8 additional cases. A conference was therefore arranged between senior naval medical officers and Territorial Department of Health doctors to pool knowledge and determine what additional procedures, if any, should be instituted in order to bring the epidemic under control.

As a result of this conference, and in view of the fact that the Navy Department total personnel attack rate had now reached 70 per 100,000, or for dependents, of 120 per 100,000 (primarily in children under 10 and women over 20) it was felt that perhaps mass immunization of these groups was indicated. The National Research Council's criteria for mass immunization or community prophylaxis are as follows:

"It is suggested that an area qualifies for initial consideration for community prophylaxis only if it achieves a rate 40 per 100,000 within a period of not more than 1 or 2 months, and has a sharply rising weekly incidence." In view of the high attack rate among Navy dependents, and the fact that 19 of the cases had occurred between November 1 and January 8, the National Research Council's criteria had been exceeded, particularly for the dependent group.

The study conducted by Dr. Salk, of the University of Pittsburgh, which includes more than 600 persons, showed that 60% of the children between the ages of 3 and 8 years had no polio antibodies. More than 30% of the group had antibody for one type of poliomyelitis, and considerably less than 10% had antibodies for 2 types of poliomyelitis. Only a very occasional child had antibody for all 3 types of virus. With increasing age, a higher proportion of persons had antibody for one or more types, but even in the older age group, a significant proportion of the people lacked antibodies against one or more of the polio viruses. It is likely the same picture exists in population groups of other areas.

Therefore, beginning January 11, gamma globulin was made available on a voluntary basis to navy dependents between the ages of 6 months and 10 years. On January 14 the mass immunization procedure for navy dependents was completed, globulin having at that time been administered to 6,700 dependent children. While the navy is not responsible for the dependents of civilians employed by the Navy Department, considerable pressure and psychological influence were exerted on behalf of civilian children resident in the housing areas experiencing poliomyelitis. Consequently, on January 15, gamma globulin was made available on a voluntary basis to civilian dependent children in the housing areas, and 115 were given gamma globulin. The epidemic continued unabated through the balance of the month of January, resulting in a total of 11 cases for the month, and has continued into the month of February with 9 additional cases having been reported and diagnosed as of February 22.

Additional conferences of the senior naval medical officers have been held weekly; additional recommendations have been considered, and a number of additional control procedures have been recommended to the personnel of the district. These additional measures consist of closing the nursery schools, and discontinuance of meetings of Brownies, Cub Scouts and other similar groups. Discouraging children's parties, particularly those at which food is to be served, and the avoidance of strenuous or fatiguing exercises, particularly those involving in addition chilling, such as experienced in the swimming pools, were also recommended.

As more cases appeared and more epidemiologic investigations have been completed, it appears that the factor most prevalent in the spread seems to be the communal food preparations served at both children's and adult parties, especially such things as popcorn, where youngsters will each reach into a bowl or bag and thus contaminate, with saliva, the remaining portion for others to consume. The same thing pertains to cheese dips in which potato chips are used as scoops by adults, each leaving some residual in the communal mix. The sharing of candy bars and ice cream by youngsters, both in movie theaters and at children's parties, and the dish of salted nuts in which each dips for his portion, usually with a few slipping off the fingers and remaining in the container for the next individual to consume, are other examples. Such procedures are hard to control, but information has been provided to the families throughout the area for their own guidance and instruction of their children, tending to discour-

age such social activities until the epidemic has terminated.

Some interesting figures have developed during the present epidemic. The 32 cases experienced since November 1 break down into the following age groups:

| | |
|---|---|
| 0 through 5 years | 10 |
| 6 through 9 | 6 |
| 10 through 19 | 3 |
| 20 through 29 | 8 |
| 30 through 39 | 4 |
| 40 and over | 1 |

Of the 32 cases, 20 are paralytic and 12 are non-paralytic. Nineteen have been from officer families and 13 from enlisted families. Perhaps this difference in officer personnel families is an index of the higher social activity of both parents and children. As a further indication of this higher social activity, the intimate contacts of the last 5 officer cases have averaged 29 per case, whereas the intimate contact of the last 3 enlisted family cases averaged only 5 per case.

The Navy Medical Department personnel are continually looking for ways to more effectively control the spread of poliomyelitis, and will introduce any measure that has a probability of improving the situation. We trust that the epidemic will taper off before the regular polio season is reached on Oahu. The present outbreak, occurring during the winter months, is an unusual experience for this area. When civilian cases are again being experienced, it is hoped that the type of poliomyelitis involved can be determined. In the event that it proves to be Brunhilde strain, it might then be advisable to obtain blood donors from the locale and have their serum processed into gamma globulin for use in this particular area. It is likely that such gamma globulin would have a higher immunizing capacity for the Brunhilde strain experienced here.

We also hope that the vaccine, which is undergoing a validity study on the mainland this year, will provide effective immunization against all three types of poliomyelitis. The vaccine to be used was developed by Doctor Jonas E. Salk, of the University of Pittsburgh. This vaccine is to be produced by 5 companies, and it is hoped that sufficient will be available to inoculate at least 500,000 school children. The vaccine is composed of the killed virus of all three polio virus types, which have been grown in test tube cultures of monkey kidney tissues.

The virus is killed by exposure to formaldehyde and is prepared in a watery solution which is designated the aqueous type of vaccine. Each child will receive 3 injections of 1 cc. each, the first 2 doses at weekly intervals and the third, or booster, four weeks later. The most rigid scientific safety tests that can be devised for new vaccines have been set up to insure the safety and complete purity of each bath of poliomyelitis vaccine to be used in the validity test. No vaccine will be used until the Laboratory of Biologics Control of the National Institute of Health (United States Public Health Service), Dr. Salk, and each of the commercial laboratories making the vaccine have tested it and certified it to be safe.

The procedure used prior to the certification of safety requires that each of the above laboratories first inject the vaccine into a series of test tubes containing tissue culture to see if any live virus might accidentally be present. The vaccine culture from the first series of test tubes will be in turn injected into another battery of test tubes, and this process will be continued through six stages. Such an elaborate procedure gives every opportunity for any live virus to be detected. If there is the slightest trace of such a live virus, the batch of vaccine will be discarded.

Secondly, each batch of the killed virus vaccine will be injected into the brain tissue of ten healthy monkeys who will be kept under strict observation for over three weeks to see if they show any signs of developing polio.

Thirdly, the killed virus vaccine will be injected into mice and rabbits to check for outside contaminating agents or impurities that might cause side effects.

The certified vaccine will then be injected into 2 groups of school children. One group will consist of second grade children, using the first and third grade children for controls. The other group will consist of half of the first, second and third grade children, the remaining half being given an innocuous control injection. The areas selected for the validity study will be made by a committee of outstanding experts in the Public Health Field. The 200 or more counties to be included in the vaccine study are selected mainly on the following basis:

1. High polio incidence for past five years;
2. High epidemic rate in the past five years during the period June through September;
3. High attack rate in specific age groups;
4. Adequate health and educational facilities; and,
5. Socio-economic factors, geographic location etc.; to provide a significant cross section of the United States for incorporation in the validity study.

It is the hope of everyone that this extensive validity study will prove the vaccine to be efficacious in the control of this ravaging disease.

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# AMEBIC GRANULOMA OF THE CECUM

## With Report of Two Cases

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THE American literature of the past twenty-five years contains few reports of amebic granuloma of the large bowel. These often refer to the infrequency of this lesion in the United States.



DR. GILES

During the past six months, we have had the opportunity of seeing 2 cases which have brought to mind certain important factors in the diagnosis of amebiasis. Scant attention has been given to the fact that amebiasis may produce a granulomatous mass which can be easily mistaken for carcinoma of the bowel. Ordinarily, amebic involvement of the colon is thought of as being characterized by multiple punched-out, flask-shaped ulcers of the mucosa and submucosa, with little or no evidence of inflammation between the ulcerations. Amebas are found in large numbers in the base and wall of the ulcers and in the stools.

The granulomatous lesion may be commoner than is generally believed. The most common sites of amebic granuloma are in the cecum and rectosigmoid, and in this condition amebas are not readily demonstrated in the stools. This lesion, which has frequently been compared to the tuberculoma, consists of a mass of granulation tissue resulting from repeated amebic invasion and tissue destruction with subsequent scar tissue and granulation production resulting from the body's attempt to heal and repel the amebic invasion.[1,2] This process, which occurs beneath the mucosa, frequently results in extensive sloughing necrosis on the mucosal side of the bowel wall. It may be confused with malignant tumors or other forms of inflammatory granulomas. Clinically, such cases are characterized by evidences of chronic infection, such as a long history of intermittent diarrhea; anemia; localized and generalized abdominal pain; gaseous indigestion; distress in the abdomen, particularly on the right side; tenderness to pressure; and signs at times of partial or complete intestinal obstruction.[3]

Since amebas are frequently not found in the stool and partial or complete intestinal obstruction frequently results from the amebic granuloma, many of the cases reported are diagnosed at surgery which has been undertaken to relieve the obstructive symptoms. It is important that a preoperative diagnosis be made, since the present methods of treatment are so effective in eradicating the granuloma from the colon that surgery may not be necessary.

### Radiographic Findings in Amebiasis

In acute amebic dysentery, the barium enema is often normal. In about 10 per cent there is irritability of the cecum, and the mucosal pattern of the whole colon may be coarse. This is due to a heaping up of the folds from edema, producing a so-called "confused type" of pattern.[4,5] Hodes and Mammoser[6] have also demonstrated that the small bowel transit time is appreciably shortened with acute amebic dysentery. These are non-specific findings and are probably of little help in the diagnosis.

In the diagnosis of chronic amebiasis, the barium enema is of the utmost importance.[7,8,5] Here the clinical and bacteriologic examination does not always furnish the diagnosis, and the X-ray frequently will show a suspicious or almost diagnostic lesion.[3,9] The changes are primarily in the cecal region. The normal sac-like appearance of the cecum is replaced by a gradual narrowing of the cecal walls until it assumes the appearance of a cone. The walls are shaggy and irregular. Localized regions of narrowing and filling defects may

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be present. The cecum as a whole is often irritable, emptying itself as rapidly as it is filled. This irritability is more easily seen when barium is given by mouth than via the enema. The ileocecal valve lips are quite edematous. Despite this, the valve itself is widely patent. The terminal ileum is almost never involved, which is the opposite of tuberculosis. Other segments of the colon may show areas of narrowing, particularly in the ascending and proximal transverse colon. A rare late case will show a smooth mucosa with a pipestem appearance throughout, somewhat similar to old ulcerative colitis.

The acute involvement of the distal colon, where the punched-out ulcers are visible with the proctoscope, rarely produces radiographic evidence. A saw-toothed margin to the colon may be seen when the ulcerations are numerous and deep. This is similar to the picture produced by acute ulcerative colitis.

The major differential required is from cecal tuberculosis. This can produce the same picture, although typically it involves the terminal ileum, and such involvement, when present, assists in the differential. An active pulmonary lesion is usually present with tuberculosis. If the stool examination does not offer differential proof, a trial with anti-amebic therapy will establish the diagnosis. The cone-shaped cecum caused by Entameba histolytica will disappear or approach normal.

The differential from carcinoma is usually obvious.[2,10] The gradual transition from normal colon to amebic granuloma is typical of inflammation rather than tumor. No sharp "shelfing" or "spurs" are present. A small change in caliber with different amounts of filling can be produced in the ameboma. There is no pain and the obstruction to barium is relatively incomplete. In carcinoma the size and shape is rigid, the obstruction more complete, filling produces pain, and the involved segment is usually shorter. Classically, a carcinoma does not involve the cecal tip. An absolute differential is obtained following treatment: the ameboma will regress or disappear.

## Case Report

CASE 1.—First seen May 6, 1952, was a 34 year old white housewife complaining of intermittent diarrhea, each attack lasting from twenty-four to forty-eight hours, with marked fatigue, nervousness, and insomnia. These symptoms had been present since March, 1952. Right lower abdominal discomfort occasionally occurred just prior to the menstrual period; however, there was no pain associated with the diarrhea. The diarrhea amounted to about 5 bowel movements of loose, watery

[10] Zucker, G.; Amebic Granuloma of the Cecum, Rev. of Gastroenterology 14:609 (Sept.) 1947.



FIG. 1A.—Shortened cone-shaped cecum with shaggy walls.



FIG. 1B.—Coarse, scrambled mucosal pattern.



FIG. 2.—After treatment the cecum distends almost to normal size.

material without blood, daily. No weight loss had occurred.

She gave a past history of having lived in South America and approximately five years prior to this time had been found to have had amebic infestation of the stool on two occasions. Each time the stool had cleared, and the diarrhea had stopped, following routine treatment. No barium enema had been done as far as could be ascertained. In March, a few amebic cysts had been found, and the patient had been given Terramycin. This had resulted in about two weeks' freedom from diarrhea and a loss of the feeling of fatigue and weakness for about the same period of time. After two weeks, these symptoms had returned and had persisted until she was seen by us in May.

Physical examination disclosed only moderate tenderness in the right lower quadrant of the abdomen. A sigmoidoscopic examination revealed a normal rectal and lower sigmoid mucosa. The stool examination after Epsom salts catharsis on two occasions did not reveal any amebas or amebic cysts.

The barium enema examination showed the cecum to be shortened and conical in shape. The length as measured from the ileocecal valve to the tip was less than one-third of the norm. The cecal wall was shaggy. The mucosal pattern was coarse and "scrambled." The ileocecal valve lips were enlarged with a resultant narrowing of the lumen of the ileocecal region itself. At fluoroscopy, the cecum never distended beyond the cone-shaped appearance seen on the films, and it showed some irritability. Localized tenderness was present over the area with a deep resistance to palpation, plus the sensation of a mass. The cecum and terminal ileum moved as a unit on pressure, due to the surrounding adhesions. The remaining colon appeared normal (Fig. 1).

The impression was that an amebic granuloma of the cecum was present. She was given Terramycin, 250 mg. every three hours for two weeks, followed by a rest period of one week, and this was followed by another two weeks of Terramycin.

A repeat barium enema two months later, following the cessation of Terramycin, showed the cecum to distend freely almost to a normal size. The mucosal pattern was still slightly coarsened. The most distal loop



FIG. 3A.—Shortened cone-shaped cecum with the remaining colon normal.



FIG. 3B.—Ragged cecal mucosa with a small granuloma filling defect medially.

of the terminal ileum was still adherent to the cecum, but the other adjacent loops were free (Fig. 2).

When seen six months later, the patient was asymptomatic.

CASE 2.—A 37 year old Japanese man was seen in March, 1953. At this time he was complaining of blood in his stools and blood passing from the rectum following bowel movements. There was no pain associated with the movement, and this bleeding had occurred with each bowel movement for about one year. The patient had no weight loss, and there had been no change in bowel habits. The stools were usually soft and small in caliber.

Physical examination was normal throughout, except as pertained to the bowel. On sigmoidoscopy, a ragged ulceration, 1½ x ¾ cm., was seen, located approximately 3 cm. above the ampulla. A biopsy was done and reported as being typical of amebiasis. The blood count at this time revealed 15.2 grams of hemoglobin, 4,950,000 red blood cells, and 12,300 white blood cells, polymorphonuclear cells 92%, eosinophiles 4%, and the lymphocytes 7%. A barium enema revealed the following: The large bowel showed no abnormality, except for the cecum, which was cone-shaped in appearance and short. The caliber was fixed and did not change with finger palpation, with various amounts of filling of the colon, nor after evacuation. The mucosa was very ragged and irregular, with a filling defect medially. The ileocecal valve was patulous. There was some coarseness to the mucosal pattern in the distal centimeter or two of ileum. Despite the marked cecal abnormality, the appendix filled and looked normal. After evacuation, a tiny, saw-toothed shagginess was demonstrable in the rectosigmoid region, with a coarseness to the mucosal pattern in this area. During fluoroscopy, this region showed no evidence of spasm (Fig. 3).

Stool examinations from the patient revealed no ova or parasites at any time; this included a very careful search for amebas. The stool specimens of the patient's 5 children and his wife were carefully examined, and no ova or parasites were found in 3 specimens from each member. The patient himself was started on Aureomycin, 250 mg. every three hours for two weeks. At the end of two weeks, sigmoidoscopy was again done, and at this time there was complete healing of the previously described ulceration. No bleeding or abnormal mucosa was found.

A repeat barium enema examination was done in August of 1953, five months after treatment. It demonstrated some residual shortening of the cecum, apparently residual fibrosis. The other changes had all regressed (Fig. 4).

## Comment

We have reported 2 cases of amebic granuloma of the cecum, one of which has been typical of the protracted clinical course which is frequently seen in amebic granuloma. Case 2 has been characteristic of the more acute type of amebic disease, and the granuloma itself would not have been discovered had not a complete bowel study been done. It is undoubtedly from such lesions as this that further spread of amebic organisms occurs, and that abcess formation of the liver, osteomyelitis, brain abscess, and the other complications of amebiasis result. The newer antibiotics offer excellent help in the treatment of these conditions, so that with proper diagnosis, the morbidity of this condition may be greatly reduced, thereby decreasing the incidence of the disease, since these patients also may frequently be carriers.



FIG. 4.—After treatment the cecum has improved, but the cone shape persists due to residual fibrosis.


## Summary

Two cases of amebic granuloma of the cecum are presented. It is important to consider the diagnosis of amebic granuloma in all intestinal conditions, particularly where obstructive symptoms may be present, since it is now possible, with the use of the newer antibiotics, to treat these conditions conservatively without surgery and to obtain an excellent result. The importance of diagnosis and the roentgenologic aspects are presented.



1133 Punchbowl Street

# RETROPERITONEAL INSUFFLATION BY THE PRESACRAL ROUTE

ANDREW L. MORGAN, M.D., Honolulu

PERI-RENAL insufflation as an aid to diagnosis was first reported by Carelli[1] in 1921, and since then numerous papers have appeared in the literature with but slight modification. In this country much credit goes to Cahill,[2] whose careful study of the procedure and voluminous writings have acquainted the medical profession with it and its importance, particularly as an aid in the diagnosis of adrenal neoplasms.



DR. MORGAN

Cahill[3] reports several hundred peri-renal air insufflations with but few serious complications. Joleson feels that this procedure does have its complications of air embolism and is certainly not without danger. Cahill does admit danger in its use in the diagnosis of large retroperitoneal masses where there are numerous tortuous, thin-walled blood vessels. Hyman and Wilhelm[4] feel that peri-renal injection should be used as a diagnostic last resort. Others report as complications of the procedure, embolism, hemorrhage, and infection.[5] In nearly all of the cases reported in which complications occurred during or following peri-renal insufflation, they were the result of direct injury by the insufflating needle.

By means of insufflation by the presacral or retrorectal route, the various above mentioned complications can be avoided. Rivas[6] originally reported the use of a single paracoccygeal puncture for retroperitoneal insufflation in 1948 and has more recently presented further observations on its use, pointing to the safety of such a procedure.[7]

This procedure I have used in a series of 80 cases in which pathology in the retroperitoneal organs was suspected. This has been done with but little discomfort to the patient and without untoward reaction. By this route there is no damage to viscera or blood vessels and so the possibility of embolism, hemorrhage, or infection is remote. Rivas graphically illustrates the ease with which the injected gas diffuses in the subserous spaces (Figs. 1 & 2).

[7] Ruiz Rivas, M.: Roentgenological Diagnosis: Generalized Subserous Emphysema through a Single Puncture, Am. J. Roent. 64:723 (Nov.) 1950.



FIG. 1.—This schematic drawing illustrates the upward diffusion of injected gas in the retroperitoneal space. The kidney and adrenal gland lie within the leaves of Gerota's fascia. This sheath fuses superiorly, but lies open inferiorly.

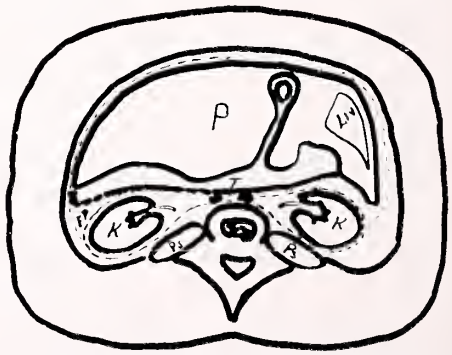



FIG. 2.—This schematic drawing represents a cross section of the upper abdomen. There is a joining of Gerota's fascia across the midline which allows injected gas to diffuse from one side to the other.

Read before the Sixty-Third Annual Meeting of the Hawaii Territorial Medical Association, Wailuku, Maui, May 1, 1953.

[1] Carelli, H. H.: Artificial Emphysema for Roentgenography of the Kidney, Bull. et Mém. Soc. Med. d'Hop. de Par. 45:1409 (Oct. 18) 1921.

[2] Cahill, G. F.: Tumors of Adrenal and Use of Air Insufflation in their Diagnosis, Radiology 37:533 (Nov.) 1941.

[3] Cahill, G. F.: Air Injections to Demonstrate Adrenals by X-Ray, J. Urol. 34:238 (Sept.) 1935.

[4] Hyman, A., and Wilhelm, S. F.: The Differential Diagnosis of Renal and Suprarenal Tumors, J. Urol. 40:737 (Dec.) 1938.

[5] Roome, N. W.: Visualization of Adrenal Glands by Air Injection, J.A.M.A. 112:196 (Jan.) 1939.

[6] Ruiz Rivas, M.: Diagnostico Radiologico. El Neumorrinon Tecnica Original, Arch. Espań. Urol. 4:228 (Jan.) 1948.

## Procedure

The patient, having previously had a preparative cathartic and cleansing enema, is placed in the kneeling or knee chest position, although it is possible to have the patient on either side with knees flexed. The coccygeal area is cleaned and the tip of the coccyx is palpated (Figs. 3 & 4). After infiltration of skin with Novocaine a 20 gauge spinal needle is introduced either at the tip of the coccyx or 1 cm. to either side of the sacro-coccygeal junction. The needle is slowly introduced cephalad and then dorsally along the anterior surface of the coccyx and sacrum, so that now the tip of the needle rests in the retrorectal space. The needle need not be introduced further than 3 or 4 cm. It is not necessary to have a finger in the rectum but I have more recently done this and found that it is a good guide.

The needle is first aspirated and then a few cc. of oxygen are injected. It will pass easily if in the proper plane. Rapid injection of oxygen may proceed. I have used from 300 to 2000 cc. of oxygen, though I feel that for the adult, 1200 to 1500 is the optimum. Helium has been used more recently by Levine,[8] who reports better visualization and faster diffusion. Some of the patients noted a feeling of fullness in both flanks

[8] Levine, B.: Use of Helium in Perirenal Insufflation: Preliminary Report, J. Urol. 67:390 (Mar.) 1952.



FIG. 3.—This illustrates the position of the patient prior to insufflation. Arrows indicate point of entrance of needle opposite sacro-coccygeal articulation. Injection also can be made just inferior to tip of coccyx. Note instruments used; to the left is a sterile blood pressure cuff inflated with oxygen. One outlet is attached to a three-way stopcock by a length of tubing. A 30 or 50 cc. Luer syringe is used. A spinal needle of 20 or 22 gauge is adequate.

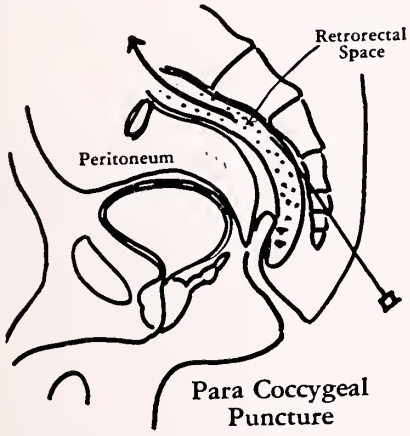



FIG. 4.—This illustrates the pelvis in sagittal section and shows the tip of the spinal needle within the retrorectal space. The left index finger can be introduced into the rectum at the time of insertion of the needle to prevent entering the rectal wall posteriorly.



FIG. 5.—Illustrated in a retrograde pyelogram showing complete obstruction at the left uretero-pelvic junction.

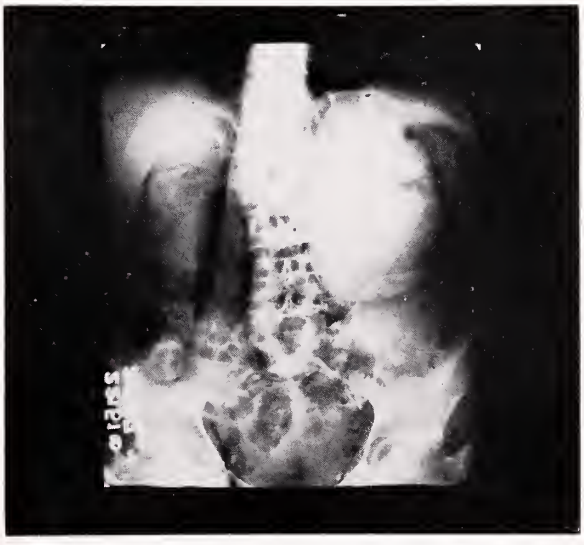
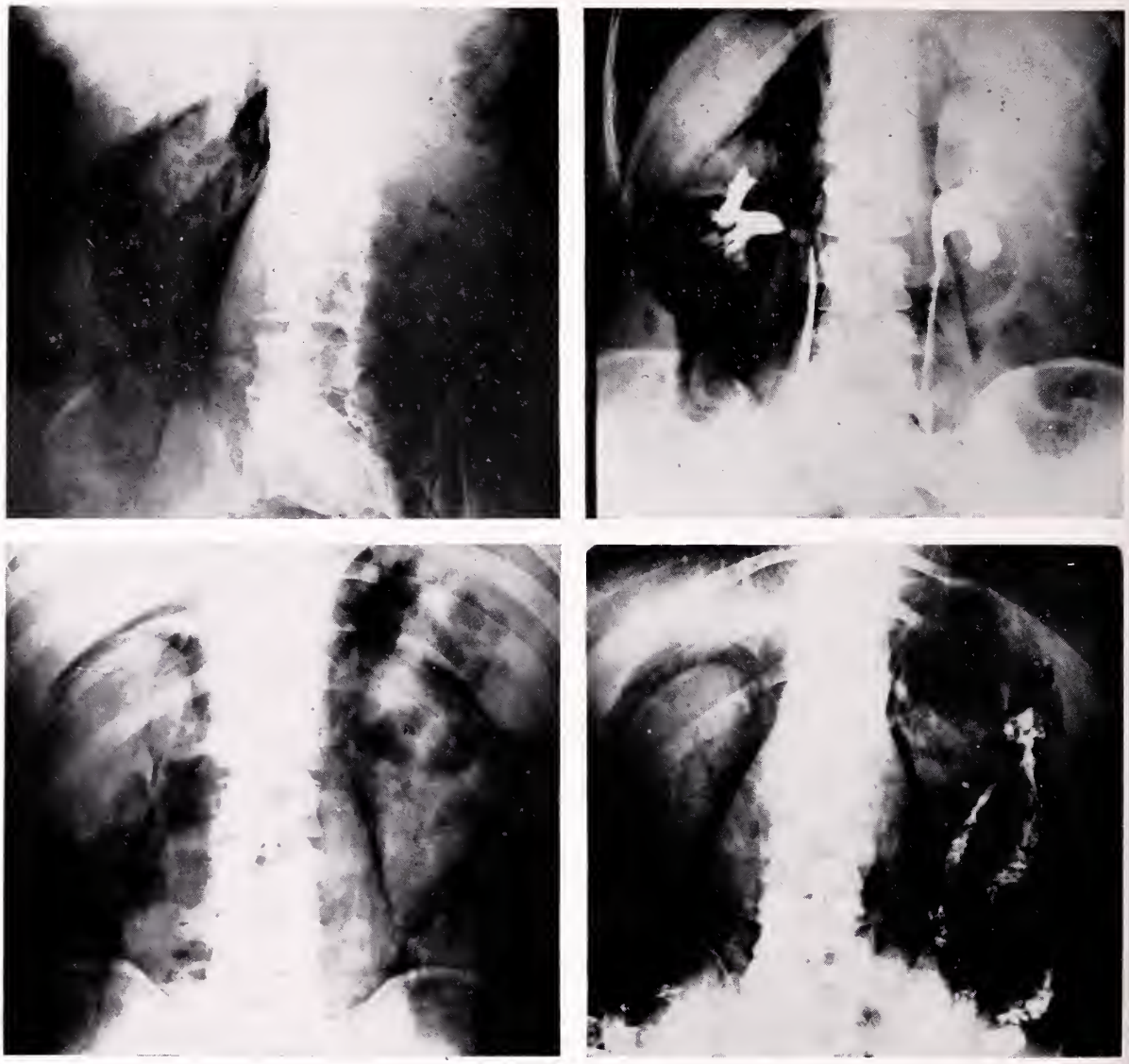


FIG. 6.—The same case one hour following presacral injection of 1,000 cc. of oxygen. Note massive hydronephrosis on left. Most of injected oxygen diffused to surround the right kidney.



FIGS. 7-10—These films illustrate the sharp renal outlines; adrenal glands. Fig. 7 (upper left) illustrates diffusion of gas on the right side only. In this case 800 cc. of oxygen were injected with the patient lying on the left side. Fig. 8 (upper right) illustrates a retrograde pyelogram following an insufflation. Adrenal gland on the right in Fig. 9 (lower left) can be clearly seen.

and abdomen and occasionally delayed fullness in the neck; however, there have been no other untoward or unpleasant symptoms. The patient is ambulated and asked to inhale deeply. It is felt this may enhance the upward diffusion of the gas.

Roentgenographic examination may be carried out to best advantage after thirty minutes to two hours. Films taken after twenty-four and forty-eight hours show the presence of retroperitoneal oxygen, but in markedly diminished quantity. Following insufflation, if indicated, intravenous or retrograde pyelograms and aortagrams can be performed (Figs. 5-10).

## Conclusion

The ease and safety of this procedure is stressed. There was little or no discomfort noted by the various subjects. The insufflation by the presacral or retrorectal route, being safer and easier to perform than other techniques, may become a more commonly used procedure as an aid in the diagnosis of retroperitoneal pathology.

It is a well known fact that the diagnosis of retroperitoneal neoplasm is a difficult one. This procedure affords bilateral retroperitoneal visualization with but one atraumatic puncture.

305 Royal Hawaiian Ave.



# *The President's Page*

Doctor, YOU are the captain of your ship. As a doctor of medicine you must depend upon yourself, your skill, your knowledge and your judgment for any decisions on diagnosis, treatment and care of your patient. This singular characteristic of the medical profession develops within each physician individualistic thinking. This is a very fine quality and is typical of the Freedom in medicine that we enjoy under our American Way of Life.

However, the very nature of this individualism renders the physician less able to act collectively on problems of vital concern to the medical profession as a whole. Engrossed in the problems of the sick and injured the physician finds himself intensely absorbed in the complexities of the diseases or injuries that challenge his skill and judgment. Problems in the business field of medicine, problems of a socio-economic nature, and problems of Public Relations naturally receive very little of his attention, and the "let George do it" attitude is frequently visible through the physician's cloak of individualism.

We can advance our cause by producing visible evidence of our sincerity and visible evidence of progress, not only of progress in the arts and sciences of medicine but also in the field of public relations and of socio-economic endeavor. By your decrees and directives limiting the powers of your officers and committees little can be done at an association level in the performance of acts designed to promote good public relations and to render decisions on a collective basis concerning Medicine's relations with management, labor, insurance carriers, hospitals, and the public.

The responsibility for performing good public relations that will benefit you and in the end benefit the medical profession as a whole is yours, and yours alone. Good public relations, good relations with any organization and such acts designed to promote good will, begin right with YOU in your office. Therefore, every physician must remember that he as an individual is his best public relations agent and he must remember to handle his patients diligently, wisely, and skillfully, not only medically but also socio-economically.

In retiring from the presidency of the finest medical association in the land I wish to thank all of you with whom I have been associated, and particularly the members of my committees, for the excellent cooperation that you have given me during my term of office. You bestowed upon me a great honor when you elected me President of the Hawaii Medical Association and I have tried to serve you diligently, industriously, and wisely to the best of my ability. May I ask that you give President Larsen the same fine cooperation that you so generously gave to me.

With fondest Aloha, I am,

R. K. Thungstrom, M.D.

Hawaii
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## [EDITORIALS]

### The Rehabilitation Center of Hawaii

In August, 1950, at the request of five agencies* concerned with handicapped persons, the Oahu Health Council began a study of the problem of rehabilitation in Honolulu. In February 1953, with the financial assistance of the Public Health Committee of the Chamber of Commerce, the Council's Rehabilitation Committee brought Dr. Howard A. Rusk from New York to speak on rehabilitation and consult with them.

Dr. Rusk's inspiring visit, added to the groundwork already laid, resulted in the rapid maturing of plans for establishing a rehabilitation center. At this point Kauikeolani Children's Hospital unexpectedly entered the picture with an offer of ground space, buildings, and such ancillary services as laundry, kitchen, laboratory and x-ray facilities. A local orthopedic surgeon† agreed to serve on a volunteer, part-time basis as medical director; and on September 15, 1953, the Rehabilitation Center of Hawaii opened its doors.

The "Rehab" Center today covers 8800 square feet, with 18 ward beds and facilities for handling 50 out-patients daily. Equipment is available for occupational, physical, speech, hearing and play therapies. Henry N. Thompson, Jr., is Assistant Director, and George E. Patterson is Placement and Public Relations Counselor. There is one psychiatric social worker, and there are 2 occupational and 4 physical therapists.

There are 15 in-patients now (6 have been discharged) and over 40 handicapped persons are undergoing rehabilitation on an out-patient basis. A number of dramatically successful rehabilitation projects have been carried near to completion, such as making a paraplegic, totally bedridden for 12 years in a local hospital, almost entirely self-sufficient at the wheel-chair level; and a quadriplegic, helpless for 13 years, self-supporting (in a wheel-chair) writing radio and television scripts.

A large and effective Placement Committee of influential local citizens assists the Center in finding work at which the Center's alumni can become at least partially self-supporting—the ultimate goal for them all.

The formation of the Rehabilitation Center of Hawaii has been a community wide effort, made possible by the effective cooperation of many different agencies through the Oahu Health Council. Both government and private agencies cooperated at both exploratory and planning stages. Much credit is due the National Foundation for Infantile Paralysis for their generous financial support at the outset, and to Children's Hospital for their timely offer of essential physical facilities, as well as to the thirteen physicians who have donated their professional services to the institution.

The cost-saving potentialities of the Rehabilitation Center are incalculable. The difference between keeping a man in bed in a county hospital—or even in his children's or his own home—and having him up and around on crutches or in a wheel-chair, doing a job, earning a living, is enormous. It would be amply justified, of course, purely from the spiritual and humanitarian aspect; but it is on equally sound ground in terms of hard, cold dollars and cents. An expenditure of roughly $3,000, for example, has already put a stop to bed care which had already cost the taxpayers about

* The National Society for Crippled Children and Adults, the Vocational Rehabilitation Bureau, the Oahu Tuberculosis and Health Association, the Department of Public Welfare, and the Bureau of Sight Conservation.

† Dr. Richard S. Dodge.

$40,000 and was slated to cost them fully twice as much more in the next 25 years. This could be multiplied 50 times on the basis of the known cases, and perhaps 250 times for the whole community—though this is a guess, and a far from educated one at that.

Moreover, this value is concerned with persons already disabled. The Center has much to offer them, but it also has much to offer the recently injured. The narrower the gap between the disabling event and the beginning of rehabilitation training, the more efficient and effective that training is. Narrowing this gap will require education of physicians to full and free acceptance of this new and—to most doctors—rather unfamiliar concept in medical care. We hope this brief account will give them a little start along the road. The Rehabilitation Center of Hawaii is here, filling a long-existing need. Let's give it our full support!

## Poliomyelitis in Hawaii

The curious epidemiologic pattern of poliomyelitis in Hawaii is described in articles by Fletcher[1] and Enright[2] elsewhere in this issue of the Journal. It is virtually natural vaccination, with infection occurring so regularly during infancy—when paralysis is even rarer than it is during childhood—that we have the paradox of a very high real attack rate but a rather low apparent one. It has been estimated[3] that about one case of polio in each thousand develops manifest paralysis, the ratio probably being lowest in infancy and highest among adults.

Vaccination against poliomyelitis, using infected monkey spinal cord, was first tried with a single virus strain in 1935, with doubtful results and a few mysterious accidents. Next tried was passive immunization with gamma globulin, and—though time may modify the verdict somewhat—the expert committee of the U.S.P.H.S. has decided that it is unreliable. At best it can apparently protect for only about 3 weeks, starting 2 weeks after the injection.

Active immunization with a trivalent killed-virus vaccine is known to be effective in monkeys, and extensive trials of one such vaccine (Dr. Jonas Salk's) were begun in April among mainland school children. Questions to be answered are two: (1) Is it safe? Will it produce less paralysis than polio does? Will it produce any kidney damage? And (2) Is it effective? Will it prevent, or modify, or merely postpone, paralytic or other forms of poliomyelitis?

Hawaii is not a good place to try an experimental vaccine. Polio is not common here: only among Caucasians, and only on Oahu, are anywhere near as many persons paralyzed by polio, as *die* of tuberculosis. As to fatalities from polio, only 12 occured in Hawaii from 1941 to 1952—a period during which 130 died of heart disease, 148 from cancer, 193 from tuberculosis, and 800 from accidents!

Moreover, polio in Hawaii is truly "infantile," even if it is not often "paralysis," as Enright shows. School age children, so prone to polio on the mainland, are relatively immune here. Indeed, our natural situation with regard to poliomyelitis is so good already, that it will take a mighty effective vaccine to improve upon it.

## It Really Can't Happen Here

A blessing we may well be reminded of once in a while is the fact that the following vivid case report by E. H. Andrews and C. B. Pollard[1] really couldn't happen in Hawaii.

> Case 9.—The following is a verbatim history given by Mr. G. R. of his experiences in connection with a [rattle]snake bite suffered on July 2, 1951:
>
> "This happened on the second day of July . . . My three little boys were helping me pick blueberries . . . We had been picking in the bushes all evening and looking before we stepped . . .
>
> "I put my left foot between me and the boy, my oldest boy, without looking. When I put it down, something struck me in the leg. When I looked, there was a hole about as large as the end of my little finger on my left ankle, on the outside. Blood was spurting out. I looked down and saw the snake with his head lying in the center of the coil, ready to strike again. About that time everything turned yellow to me, just as yellow as anything you ever seen. I told the boy to get back, that there was a big snake there. He screamed and ran. When he screamed, I pulled my foot back and went away about three steps, then turned and went back to kill the snake with my pistol. I almost put my foot on him again. I shot him three times with my .32 Special pistol.
>
> "I walked a few steps away to a little road, sat down, rolled my pants up to keep the blood off, corded my knee and called the oldest boy. I gave him my knife and told him to cut a cross over the bite. He screamed all the time like something was killing him, but he cut it and he did a good job. We started to town then to try to get some help . . . Everything still looked yellow until I got to Williston to the doctor. In two minutes after the snake bit me my throat was perfectly dry, and my nose

[1] Fletcher, R. H.: Poliomyelitis: Navy Cases on Oahu in 1953, HAWAII MED. J. 13:355 (May-June) 1954.

[2] Enright, J. R.: Epidemiology of Paralytic Poliomyelitis in Hawaii, ibid., p. 350.

[3] Paul, J. R.: Immunization against Poliomyelitis: Its Present Status, Connecticut State Med. J. 18:140 (Feb.) 1954.

[1] Andrews, E. H., and Pollard, C. B.: Report of Snake Bites in Florida and Treatment: Venoms and Antivenoms, J. Florida Med. Assn. 40:388 (Dec.) 1953.

felt like it was four inches across. I couldn't spit, but I didn't want anything to drink either. The wound felt just about like a stick had stuck in my leg . . .

"The first pain I felt was just before we got to Williston. It was the awfulest pain I ever felt and it was in the calf of my left leg, just above the snake bite, and kept coming up and up. Just as they carried me in the doctor's office at Williston it cleared my left hip. Mr. Dobbins, the undertaker, said I turned dark.

"The further I went the worse my mind got until it went blank. About the fifth day after I came here, my leg split all the way down in the back; after that I came back to my right mind and started getting better. I've been getting better ever since."

## The Audio-Digest Foundation

Fresh-frozen post-graduate lectures are now the order of the day. California has done it again. For $3.75 per hour without lantern slides, or $5.50 with them, you can get up-to-the-minute tape-recorded lectures in general medicine or the specialties—*less than the blank tape would cost you at retail!*

The basic service is a weekly one-hour tape designed for general practitioners, holding 20 or 30 abstracts from current medical literature, selected by a board of medical editors headed by Dr. Edward C. Rosenow, Jr. of Pasadena.

Semi-monthly digests in the fields of surgery, internal medicine, and obstetrics and gynecology are also available. Special lectures and panel discussions on one-hour reels, many of them illustrated with film strips made from the speaker's own slides, are being produced too.

And all the profits are to be turned over to the American Medical Association's Medical Education Foundation! The California Medical Association, which owns the Audio-Digest Foundation, has certainly performed an outstanding public service in purchasing, sponsoring and operating this philanthropic and worth-while enterprise.


Announcing the

**SIXTH CONGRESS**

of the

**PAN-PACIFIC SURGICAL ASSOCIATION**

The Sixth Congress of the Pan-Pacific Surgical Association will be held in Honolulu, October 7-18, 1954.

An outstanding scientific program with over 130 leading surgeons, including sessions in all divisions of surgery and related fields, promises to be of interest to all members of the profession. An extensive social program is being developed for the doctors' families.

The Association has been appointed as travel agent for those attending the Congress and it is important that all hotel and travel reservations be made through the Honolulu headquarters of the Pan-Pacific Surgical Association.

For further information regarding registration, reservations, etc., write to F. J. Pinkerton, M.D., Director General, Pan-Pacific Surgical Association, Suite 7, Young Building, Honolulu, Hawaii.

# This is What's New!

Land, sea and air sickness are dynamically the same. More simply **motion sickness** is the "sum of linear accelerations (and decelerations) along and around, lateral and vertical axes." Shaw finds surge, sway and yaw not too important in causing sea sickness but pitch, roll and heave are other matters. Especially heave; when the ship starts bobbing up and down, watch out! (*Scientific Monthly* 78: 110 [Feb.] 1954).

Incidentally, have you tried **Sillsamine**—ethically tailored to combat heave? Premature reports indicate it is about as good as 'most anything, but especially so for heave.

* * *

**Potassium,** a few years ago just another element, continues to remain in the medical limelight. Potassium is liberated from ischemic heart muscle and this can be detected by measuring potassium levels in a dog's coronary veins after ligation of a coronary artery. It is suggested that the potassium so released from infarcted or ischemic heart muscle acts as an excitatory agent and may cause **ventricular tachycardia.** (*Science* 119:200 [Feb. 12] 1954).

* * *

All is not well with the **doctors working under the big red star,** according to Soviet writers. They have too much paper work; too long hours with little chance to read their medical journals. The letters to the editor suggested, as remedies, more pay (might just as well cancel *that* reader's subscription), less paper work, more vacation time and more medals. (*New Eng. J. Med.* 250:210 [Feb. 4] 1954).

* * *

Good news for cigarette smokers! Your **lung cancer** might not be caused by the weeds after all. In Los Angeles, the very air that you breathe can cause skin cancers in black mice. The investigators collected **Los Angeles air** during the so-called smog season as well as during the "so-called" nonsmoggy season. Smoggy air contains carcinogens and nonsmoggy air may also. However, after collecting both, these investigators used only the smog extract in their animal experiments.

It has been suggested that the cigarette companies and the Los Angeles Chamber of Commerce have more than a casual interest in these results. (*A.M.A. Arch. Indust. Hyg.* 9:148 [Feb.] 1954).

* * *

Far advanced cases of **Parkinsonism** can be helped with a few minims of **procaine** in the right place, according to I. S. Cooper. Eight out of 10 patients so treated had temporary cessation of resting tremor. Some of the 8 had relief of rigidity for as long as 48 hours, one for only 45 minutes. Apparently no patient requested a second treatment; at least no mention is made of the response to a second injection. The right place? The globus pallidus, via trephine openings in the skull. (*Science* 119:417 [Mar. 26] 1954).

* * *

Fresh, green coconuts contain sterile pyrogen-free fluid that has recently been given I. V. in Bangkok, Thailand and St. Louis. The **coconut water** is hypotonic with little Na but with more K, Ca and Mg than is found in the same volume of plasma. It is not yet known whether coconut milk is antigenic (probably is) or apt to produce hyperkalemia, especially in sick, oliguric patients. (*A.M.A. Arch. Surg.* 68:167 [Feb.] 1954).

* * *

Injecting a **radiopaque dye** directly into the spleen and studying the splenoportal veins by x-ray may localize the cause of **portal hypertension,** and thus aid in the proper selection of patients for surgery. The authors—like many others—believe portocaval anastomosis is contraindicated in cirrhosis. This technique has been used locally and is of some value. (*Surgery* 35:503 [April] 1954).

* * *

**Demerol** is being advocated in **acute asthmatics** with epinephrine or aminophylline fastness. It appears to have a good anticholinergic action and a fair antihistaminic action along with its narcotic action. The usual dose is 100 mgm. subcutaneously. Respiratory depression is, of course, a contraindication. They have not had trouble with addiction but urge its use only in status asthmaticus and severe acute asthma that does not respond to more conventional treatment. (*Ann. Int. Med.* 40: 506 [Mar.] 1954).

FRED I. GILBERT, JR., M.D.

# Perhaps It's Your Nerves

## PSYCHIATRY AND THE PRACTICE OF MEDICINE

WILLIAM C. MENNINGER, M.D.

*This article is abstracted from a talk by Dr. Menninger before the alumni of Cornell University Medical College April 18, 1953. The complete talk is published in the* Bulletin of the Menninger Clinic *of September, 1953.*

Not many years ago, the majority of doctors were general practitioners. In this age of specialization in the field of medicine, there have been recurring statements that the "family doctor" is a vanishing species. The fact is, however, that many physicians, particularly in smaller communities across the country, still are general practitioners. There are many others who partially limit their practice to one specialty, but also perform some surgery, manage pneumonia, deliver babies and look after the exanthemata in a very creditable fashion. Even so, one gains an impression that they fill the older and glorified role of the "family doctor" much less frequently. Many factors in our cultural living have brought about this change.

The family doctor took more time for his patients than we think we have available in a modern medical practice. Whether he had it or not, he took time to "listen to the patient's story." Rarely did he try to see as many patients as many of us do in our offices today. By making more home calls, he saw the patient's environment. Since he saw more of the family as a unit, he became the doctor of the family rather than the doctor of one member of a family. This is unusual in the current practice of seeing most patients in highly professionalized offices or on the impersonal wards of hospitals. The family doctor did not have an office nurse or social worker who was skilled in taking a history. Nor was he trained to be so dependent upon gadgets and laboratory diagnostic aids; he had to be more self-sufficient.

In speaking of the change in medical practice in terms of the general practitioner or our increasing specialization, I do not decry the present trend. On the contrary, research within specialization has probably brought us our greatest gains in medical knowledge. Nevertheless, I think it would be wise to see what were the special benefits of the methods of the family physician that we no longer use, or at least tend to lose sight of in our present manner of practicing medicine. I dare to suggest that if we were able to impart the increasing knowledge and experience we have gained in the field of psychiatry in a useful way to all practitioners of medicine, they might recapture some of the qualities, perhaps some of the most effective assets, of the old time "family physician."

From experience and practice in psychiatry, we have learned much about human behavior that increases our understanding of healthy as well as ill people. We can now make comprehensible medical observations which formerly had been incomprehensible. We now have a scientific basis for the interpretation of attitudes and behavior, reactions between people and toward things. Research and experience have led to an increasing agreement about many principles underlying the diagnosis and treatment of mental illness. In retrospect, we can see that some of these principles were used intuitively by the family doctor. My assumption is that most, if not all of these can be used in all branches of the practice of medicine, whether it be general or specialized. Going further, were these principles accepted and applied by all physicians and adapted to their special situations, the result would be a more effective and scientific brand of medical practice. I should like to call attention to some more important of these basic tenets.

### Acceptance of the Validity of Psychological Data

Almost from its beginning, scientific medicine has focused its attention on man as an anatomical-physiological-chemical unit. For too many years, the study of human behavior was not included in medical education and practice. Even yet, the medical curriculum includes no courses in physician-oriented psychology, sociology or anthropology. The result is that, in general, physicians have interested themselves in the misbehavior of the stomach and the pancreas, but not in the misbehavior of the total organism in relation to its environment. The medical student was taught only that if no pathological organic condition was found, the patient was not sick; the patient only *thought* he was.

Medical education has greatly improved in this respect in the last ten years. There is an increasingly helpful body of knowledge, widely disseminated, regarding the power of the emotions acting on the soma, even to the production of organic disease. There is more awareness on the part of physicians of the etiological significance of social factors, of the direct bearing that interpersonal relationships have on the cause and course of an illness, and of the high degree of specificity of psychological supports and stresses for each individual. One of the fundamentals of psychiatric

practice, applicable to all medicine, is the assumption that psychological and social data are just as valid and of equal importance in the diagnosis and treatment of most illnesses, and of greater importance in many, than are the anatomical, physiological and chemical data.

Because of the acceptance of the validity of psychological and social data, the psychiatrist investigates all aspects of the total person—physical structure, body chemistry, psychological life, and social relations. These are all interrelated and interdependent parts, so that every reaction to a stimulus, whether it originates within or without the body is a composite of the responses of the various segments of the person.

Psychiatry is then, in a very real sense, "comprehensive medicine." Its investigation can never be limited to a particular set of organs. Nor can any physician with a psychiatric point of view see his patient as being merely a case with an abscessed liver or a gun shot wound of the femur.

### The Physiology of the Personality

Physical life depends in essence on an energy system. It is a continuous cycle of anabolism and catabolism. Similary, psychological life is a struggle between two opposing energy forces, one a hostile-destructive-aggressive drive, and the other a loving-constructive-erotic drive. The ego portion of the personality has the function of controlling and modifying the primitive expression of these energies into socially approved behavior, and of so fusing the two drives in the mature, healthy adult, that the undesirable aspects of each are neutralized by the other.

The ability or inability of the conscious portion of the personality to manage these primitive energy drives determines one's attitudes and behavior. There are many different methods that the personality uses to control and direct this energy, which are collectively identified as psychodynamic mechanisms. Thus, for instance, unconscious hostility, which is prevented by the conscious portion of the personality from being expressed, may be turned upon the self in the form of precordial pain or hypertension.

### The Homeostatic Quality of the Personality

A fundamental of psychiatry, as it is of all medicine, is that any organism tries to maintain homeostasis. This is true of an individual cell and of the most complicated organ. In emotional and mental illness, the development of a symptom or syndrome—be it an illusion, headache or a behavior disorder—represents attempts by the individual to maintain his homeostasis. In other words, symptom formation is an attempt at "self-cure," a way of coping with some internal need or conflict or pressure.

The maintenance of psychological equilibrium requires us to "rise to the occasion," to adjust to a new experience, to mobilize support when under great stress.

The acceptance of this homeostatic principle as applicable to an interpretation of mental and emotional distress is sometimes difficult for the physician. It is much easier to ignore than to study about what we don't understand.

If the physician would keep in mind this homeostatic principle, it could help him remain objective and scientific in his evaluation of psychological and social phenomena.

### The Development of the Personality

The adult personality is very largely the result of two factors: The inherited characteristics, and the effect of relationships and experiences during infancy and childhood. It is believed that along with physical traits, certain psychological characteristics are inherited, such as intelligence and special abilities. Knowledge of these inherited factors is still limited and somewhat controversial. There is, however, no longer disagreement among psychiatrists about the importance of the environmental factors of infancy and childhood in the molding and shaping of the personality.

The events and relationships of these very early years are factors which determine the nature of the adult personality—as the child learns or fails to learn how to relate himself to people; as he learns to accept frustration easily or with difficulty; as he learns or does not learn to accept reality and to conduct himself in a socially approved fashion.

### The Concept of Illness

If we are to consider the psychological and the social aspects of our patients, it is obvious that we cannot limit the concept of disease to an anatomic-physiologic-chemical or mechanistic disorder which is localized in one part of the individual or affects one bodily system. The tendency to do this is still reflected in our system of nomenclature.

It is not to deny the practicality of the use of our nomenclature that I raise this point. Rather, it is to emphasize the fact that we have been trapped, because of medical evolution into a concept of disease as affecting *an* organ or *a* system. In our own psychiatric practice, in order to telescope our findings in diagnostic terms, we found it necessary in every case to make three diagnoses—physical, psychological and social. Only by such a system could we describe the person rather than merely his disease.

# The Honolulu County Medical Library

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## Recent Acquisitions

**Concer**

Combes, F. C. *Coal tar and cutaneous carcinogenesis in industry.* c1954. (gift of publisher).
Homburger, Freddy, ed. *The physiopathology of cancer.* c1953.

**Circulotory System**

Wiener, A. S. *An Rh-Hr syllabus.* c1954. (gift of publisher).
Wiener, A. S. *Rh-Hr blood types.* c1954. (gift of publisher).
Yorke, E. T. *Salt and the heart.* c1953. (gift of publisher).

**Communicoble Diseoses**

Bower, A. G. *Communicable diseases.* 7th ed. c1953. (from Nurses' Association).
Strean, L. P. *Oral bacterial infection.* c1949.

**Dermotology**

Simons, R. D. G.Ph., ed. *Handbook of tropical dermatology and medical mycology.* v.2. 1953.

**Diobetes**

Tolstoi, Edward. *The practical management of diabetes.* c1953. (gift of publisher).

**Genito-urinory system**

Davis, D. M. *Mechanisms of urologic disease.* c1953. (gift of publisher).
MacLean, J. T. *Acute renal failure.* c1952. (gift of publisher).

**Neurology and Psychiotry**

Abramson, H. A., ed. *Problems of consciousness.* Trans. . . . 4th conf., March 29-31, 1953. (gift of Josiah Macy, Jr., Foundation).
Nachmansohn, David, ed. *Nerve impulse.* Trans. . . . 4th conf., March 4-6, 1953. c1954. (gift of Josiah Macy, Jr., Foundation).
Podolsky, Edward, ed. *Music therapy.* c1954. (gift of publisher).
Ryan, R. E. *Headache: diagnosis and treatment.* c1954. (gift of publisher).
Selye, Hans *Annual report on stress. 1951.* c1951. (gift of publisher).

**Nursing** (All from Nurses' Association).

Bookmiller, M. M. *Textbook of obstetrics and obstetric nursing.* 2nd ed. c1954.
Bogert, L. J. *Fundamentals of chemistry.* 7th ed. c1953.
Brownell, K. O. *A textbook of practical nursing.* 4th ed. c1954.
Dooley, M. S. *Pharmacology and therapeutics in nursing.* 2nd ed. c1953.
Frank, Sister Charles Marie. *The historical development of nursing.* c1953.
Goodnow, Minnie. *Nursing history.* 9th ed. c1953.
Jamieson, E. M. *Trends in nursing history.* 4th ed. c1954.
Langley, L. L. *The physiology of man.* c1954.
Lyon, R. A. *Mitchell's pediatrics and pediatric nursing.* 4th ed. c1954.
Muller, G. L. *Introduction to medical science.* 3rd ed. c1953.
O'Hara, F. J. *Psychology and the nurse.* 4th ed. c1954.
Sellew, Gladys. *Nursing of children.* 7th ed. c1953.
Spalding, E. K. *Professional nursing.* 5th ed. rev. c1954.
Stafford, E. S. *A textbook of surgery for nurses.* 2nd ed. c1954.
Thompson, L. R. *Introduction to microorganisms.* 3rd ed. c1954.

**Obstetrics ond Gynecology**

Richardson, F. H. *The nursing mother.* c1953. (gift of publisher).
Wilson, J. M. *Pelvic relaxations and herniations.* c1954. (gift of publisher).

**Ophtholmology**

Michaelson, I. C. *Retinal circulation in man.* c1954. (gift of publisher).
Pinkerton, O. D. *A manual of ophthalmic surgery for nurses.* c1954. (gift of author).

**Orthopedics**

Cozen, Lewis. *Office orthopedics.* 2nd ed. enl. and rev. c1953. (gift of publisher).
Ragan, Charles, ed. *Connective tissues.* Trans. . . . 4th conf., Feb. 18-20, 1953. c1953. (gift of Josiah Macy, Jr., Foundation).

**Respirotory System**

Altschule, M.D. *Acute pulmonary edema.* c1954. (gift of publisher).

**Rodiology**

Gibson, H. L. *Copying and duplicating medical subjects and radiographs.* 5th ed. c1953. (gift of publisher).
Glasser, Otto. *Physical foundations of radiology.* 2nd ed. rev. and enl. c1952.

**Surgery**

Cattell, R. B. *Surgery of the pancreas.* c1953.

Ingraham, F. D. *Neurosurgery of infancy and childhood.* c1954. (gift of publisher).

Sweet, R. H. *Thoracic surgery.* 2nd ed. c1954. (gift of publisher).

**Miscellaneous**

Ferrer, M. I., ed. *Cold injury.* Trans. . . . 2nd conf., Nov. 20-21, 1952. c1954. (gift of Josiah Macy, Jr., Foundation).

Graham, Harvey. *A doctor's London.* 1952. (gift of Dr. Stewart).

Massopust, L. C. *Infrared photography in medicine.* c1952. (gift of publisher).

Moloney, J. C. *Understanding the Japanese mind.* c1954. (gift of publisher).

Papanicolaou, G. N. *Atlas of exfoliative cytology.* c1954.

*Quarterly cumulative index medicus.* v.51. Jan.-June, 1952. c1953.

Simmons, J. S. *Global epidemiology.* v.2-3. c1951-54.

Stevenson, G. S., ed. *Administrative medicine.* Trans. . . . 1st conf., Mar. 9-11, 1953. c1953. (gift of Josiah Macy, Jr. Foundation).

Truman, S. R. *The doctor.* c1951.

Wilson, C. C. *School health services.* c1953. (gift of A.M.A.).

Wohl, M. G., ed. *Internal medicine: its theory and practice.* c1951. (gift of publisher).

* * *

The Library wishes to acknowledge with gratitude the gift of the *Manual of Ophthalmic Surgery for Nurses* by Dr. O. D. Pinkerton. We are doubly glad to have this book in the Library, not only because it will prove useful, but also because it is another addition to our collection of works by our own doctors.

# Umi Makahiki I Hala*

## Penicillin

The Queen's Hospital has been designated as the central distributing center for penicillin for civilian use in the Territory of Hawaii. A total of 50 million units has been allotted for distribution for the first month.

## Honolulu County Medical Society

### Annual Meeting

The annual meeting of the Honolulu County Medical Society was held on Friday, April 7, 1944 at 7:30 p.m. in the Mabel L. Smyth Auditorium. Preceding this meeting, **Dr. Benyas,** retiring President, entertained the officers and committee chairmen at dinner at the Pacific Club. Forty members were present at the meeting. Reports of officers and committees were heard.

The following were elected to office:

| | |
|---|---|
| *President* | **F. J. Halford** |
| *Vice President* | **R. L. Hill** |
| *Corresponding Secretary* | **H. E. Bowles** |
| *Recording Secretary* | **M. Gordon** |
| *Treasurer* | **H. C. Gotshalk** |
| *Board of Governors* | **Jesse W. Smith** |
| | **D. C. Marshall** |
| | **S. E. Doolittle** |

## Program Committee

At the last annual meeting of the Honolulu County Medical Society it was decided to resume monthly evening meetings instead of assembling every Thursday morning, as had been done during the first complete fiscal year of the war. These Thursday mornings had been of necessity rather hurried affairs, and it had therefore become customary for the Board of Governors to conduct much of the Society's business, only passing on to the general membership such items of business as seemed particularly suitable for their consideration. This practice has been continued during the past year, partly out of disinclination to change what had proved to be a rather efficient modus operandi, and partly because the attendance at the evening meetings turned out to consist very largely of guests from the medical corps of the Army and Navy and from the Public Health Service, who could not participate in deliberations over business matters.

## Emergency Medical Services

### Epidemic of Poliomyelitis

In April of 1943 poliomyelitis reached epidemic proportions in the City of Honolulu. A group of physicians specializing in orthopedics recommended that the Kenny treatment should be available to these patients. The already overcrowded hospitals of the city and the serious shortage in personnel and equipment for applying the Kenny treatment made it imperative to have all of these patients treated in one place. The standby casualty hospital which the O. C. D. had constructed adjacent to the Shriners' Hospital was rapidly converted to a hospital for poliomyelitis and opened on April 19, as an Emergency Poliomyelitis Hospital serving the Territory.

* Ten years ago. From Volume 3, Number 5, May-June, 1944.

# Book Reviews

### Understanding the Japanese Mind.

By James Clark Moloney, M.D., 252 pp., Price $3.50, Philosophical Library, 1954.

With the aid of competent advisors, Dr. Moloney has written a monumental analysis of the mental and emotional processes of the Japanese. Written primarily for psychoanalysts of the occidental countries, the book should be ready by historians, diplomats and educators as well.

The oneness of the nation with its traditional reverence to the father (ko), obsequiousness to the emperor (chu), hesitation or deference (enryo), "face-saving" (sekentei) are among the enigmas analyzed with clarity. The centuries which have molded Japanese national policies, as well as individual behavior, can be better understood by acquainting ourselves with this book. The contained material applies almost exclusively to Japanese in Japan, or to those of the first generation living outside of Japan proper.

Books of a similar analytical nature concerning other peoples could be used as a practical basis toward better international understanding and might well be instrumental in avoiding future wars.

H. E. Bowles, M.D.

### Gynecological and Obstetrical Pathology.

By Peter A. Herbut, M.D., 683 pp., illustrated, Price $12.50, Lea & Febriger, 1953.

This is the first obstetrical and gynecological pathology of note to be written purely from a pathological standpoint by a pathologist. While it may therefore lack some of the pertinent clinical factors found in other gynecological pathologies, it is certainly more detailed on the pathological aspects as a whole. The book is an excellent supplement to the other tomes in the field and is a valuable addition to the library of all general pathologists and all obstetricians and gynecologists.

Physically, the book is excellently constructed, the print is legible, the illustrations are good, and the binding is durable.

W. Harold Civin, M.D.

### Diabetic Manual.

By Elliott P. Joslin, M.D., Sc.D., Ninth Edition, 315 pp., illustrated, Price $3.00, Lea & Febiger, 1953.

This latest ninth edition of Dr. Joslin's Diabetic Manual, as rewritten, varies little from the eighth edition but does include a wealth of information of practical use to the diabetic. Diabetes and its many complications are discussed comprehensively but in simple enough terms for the average lay person. The question and answer sections are of particular interest as they cover the typical questions which are frequently asked by patients. These answers are adequate, and emphasize the importance of careful control of diabetes by the physician.

This book is highly recommended to diabetic patients of average intelligence or their parents in order that they may have a more comprehensive understanding of their illness and the relatively normal life expectancy which can be obtained by proper supervision and good control.

Cecil A. Saunders, Jr., M.D.

### The Surgical Clinics of North America.

February 1954, Chicago Number—Gastrointestinal Surgery, pp. 1-289, figs. 1-75, $18 per clinic year, cloth binding, $15 per clinic year, paper binding, W. B. Saunders Company, 1954.

*The Surgical Clinics of North America* have for many years transmitted to their readers sound surgical principles in the field of surgery that are applicable by the clinician to the problems that are daily encountered. The February 1954 number, covering the field of abdominal surgery, is no exception to this well-established principle. The more common intra-abdominal lesions, which include gallbladder diseases, gastroduodenal ulcers and carcinoma of the colon, are discussed with clarity and in a manner reflecting the most widely accepted procedures to date.

The chapter devoted to the history of the development of the surgical treatment of peptic ulcer is interesting and depicts the trial-and-error method by which we have arrived at our present concepts of how best to proceed when confronted with such lesions.

Surgeons must of necessity be clinical physiologists in order to avail themselves of knowledge accumulated in recent years so important to the success of many surgical undertakings. This phase of abdominal surgery has not been neglected in this issue.

Anyone interested in the field of abdominal surgery would profit by devoting several evenings to careful perusal of the subjects so well presented in this Chicago number.

J. E. Strode, M.D.

### Copying and Duplicating Medical Subjects and Radiographs.

By H. Lou Gibson, 75 pp., illustrated, Price $5.00, Charles C. Thomas, 1953.

The Technical Editor of the Eastman Kodak Company knows a lot about this important subject; and so will you, if you read this interesting and informative book. Illustrations are numerous and excellent; instructions are clear and detailed; suggestions are practical.

Physicians and technicians who do this sort of work can't afford to miss this; it's both a reference text and an indispensable instruction manual.

Harry L. Arnold, Jr., M.D.

### Pelvic Relaxations and Herniations.

By James M. Wilson, M.D., 64 pp., illustrated, Price $2.75, Charles C. Thomas, 1954.

This small monograph is well written and makes for easy reading. It is an excellent review of the clinical anatomy of the pelvis in relationship to pelvic relaxations and herniations. The diagrams are simplified, as the intention of the author is to present a clearer picture to the student. All the different relaxations are described, as well as different types of repair. The principles of the repairs are given, but if one is looking for the actual operative technique, it is not to be found here. This book is recommended to those who desire a better understanding of the anatomy and the principles behind the surgery.

Gail G. L. Li, M.D.

### Chronic Iliac Pain in Women.

By H. B. Atlee, M.D., F.R.C.S. (Ed. & Can.), F.I.C.S., 65 pp., Price $2.50, Charles C. Thomas, 1954.

This book is a must for every doctor—specialist and general practitioner—who treats any part of the female between her lower costal margins and her knees.

The author presents his subject in a straightforward and easily understood manner. He does not delve into the occult or any of the super-scientific phases of medicine. He just opens the door and lets you see in a 1-2-3 manner how one should go about caring for the type of patient who is probably the most often mistreated—the human female with chronic iliac pain.

R. T. West, M.D.

### Rh-Hr Blood Types.

By Alexander S. Wiener, M.D., F.A.C.P., F.C.A.P., 763 pp., illustrated, Price $11.50, Grune & Stratton, Inc., 1954.

In this volume, Dr. Wiener has assembled the most important articles which he has authored on the Rh-Hr factors. The subject material is divided into sixteen sections, each one containing from one to eleven articles. For example, section one has the heading of Historical Background, and contains two articles; section three concerns Pathogenesis of Erythroblastosis Fetalis, and consists of nine articles. This arrangement makes this book a good reference volume.

Since all the articles are reprinted from many various journals, and the type is the same as the original, we have a variety of page make-up which, at least to me, was slightly disconcerting. The reference value of this book far outweighs this mild complaint.

Leon E. Mermod, M.D.

### Thoracic Surgery.

By Richard H. Sweet, M.D., Second Edition, 381 pp., illustrated, Price $10.00, W. B. Saunders Company, 1954.

This excellent book on thoracic surgery has been brought up to date to include certain new techniques, which have gained acceptance since the publication of the first edition in 1950. New illustrations have also been added to enhance the value of this book.

As stated in the preface of the first edition, emphasis is placed upon operative technique and as such will continue to have the greatest appeal to the surgeon.

This book will undoubtedly maintain its popularity because of its simplicity, clarity and excellent illustrations.

Yasuyuki Fukushima, M.D.

### Headache—Diagnosis and Treatment.

By Robert E. Ryan, B.S., M.D., M.S. (in Otolaryngology), F.A.C.S., 338 pp., Price $6.50, C. V. Mosby Company, 1954.

This publication gives a fairly complete list of the causes of headache. Its chief value lies in outlining methods of therapy of migraine and related types of cephalalgia. As a literary effort it leaves much to be desired: the text is extremely repetitious and frequently dogmatic, and contains numerous inaccuracies. One has the feeling that an average fourth year medical student could write more clearly on many of the subjects discussed. The section on ophthalmic head pain presented by a separate author will be useful for those wishing to acquaint themselves with generally accepted principles covering the relief of headaches by correction of refractive errors.

Howard E. Crawford, M.D.

### Surgical Infections.

By Edwin J. Pulaski, M.D., 332 pp., illustrated, Price $7.75, Charles C. Thomas, 1954.

The original intention of the author of this book was to write a small manual on antibiotic therapy. As the work progressed it became in addition a small treatise on surgical infections.

The antibiotics are discussed in detail, and many interesting sidelights on their development and explanations as to their mode of action are given. The management of surgical infections is covered fully, the main theme being that antibiotic therapy is adjunct therapy and is no substitute for the use of sound surgical principles.

There is one section on management of burns. The merits of the exposure method versus the closed method of treatment are developed at some length. A section is given to the discussion of specific infections and one to regional infections and care of wounds.

The book is well prepared and presents the most recent thinking in this field by one who besides being a surgeon is gifted with the ability to do good research and to dispassionately evaluate his results. It is a worthwhile source book for those who are having difficulty with some special type of infection or infected wounds which are not responding properly to antibiotic therapy. Most all of the answers are found in this treatise.

Dean M. Walker, M.D.

### The Nursing Mother.

By Frank Howard Richardson, M.D., 204 pp., Price $2.95, Prentice-Hall, Inc., 1953.

This is an excellent book prepared for the prospective mother. Written in non-technical terms, it has been designed specifically to help the average mother enjoy the benefits and satisfactions of breast feeding. In it the author explains the technique as well as the anatomical and physiological background necessary for successful breast feeding. Additions to the diet of foods other than milk are also discussed. Although most of his statements and recommendations concerning infant feeding are universally accepted, there are some which appear controversial, e.g., "it will be found better to begin with the unstrained, chopped or 'junior foods' rather than the 'strained baby foods.'"

M. M. Hasegawa, M.D.

### Aportacion de la Escuela Espanola A la Tecnica Endobronquial.

By S. Garcia-Vicente, M.D., Madrid, Spain, 1953.

The author presents the history of the Spanish contributions to the different endotracheobronchial techniques of our days. He describes how this work started in Spain around 1928 and how it was promptly communicated to the different medical centers of Europe and unfortunately interrupted by the Civil War with the consequence that the place of origin of these principles and techniques was easily forgotten by the rest of the World's medical centers.

It brings an extensive bibliography proving that the main principles that make possible our exploratory, diagnostic, therapeutic and anesthetic intratracheobronchial techniques of the present originated in great part in Spain.

The reading of this book would be very worthwhile to individuals interested in the history and development of our present clinical knowledge of the intratracheobronchial techniques.

Mario Lopezllera, M.D.

### Acute Pulmonary Edema.

By Mark D. Altschule, M.D., 68 pp., Price $3.50, Grune & Stratton, Inc., 1954.

This small monograph is an excellent treatise on one clinical syndrome. It consists mainly of the pathologic physiology and treatment of acute pulmonary edema. Only the essential facts are presented. The usual verbiage of medical literature has been stripped from the subject—a procedure more authors should follow.

This syndrome is a common occurrence in daily clinical practice. It is often mishandled. The book can be read in an hour and is highly recommended for all physicians to peruse.

J. L. Bell, M.D.

### Office Orthopedics.

By Lewis Cozen, M.D., F.A.C.S., Second Edition, 304 pp., illustrated, Price $5.50, Lea & Febiger, 1953.

This book is the second edition of an excellent text. The stated intent of this book is to supplement, not to replace, standard orthopedic textbooks. The author has presented many simple therapeutic methods that can be used in the office. The chapters on the back, foot and physical therapy are good.

This book should be of value to any physician doing orthopedics.

B. Allen Richardson, M.D.

### An Rh-Hr Syllabus.

By Alexander S. Wiener, M.D., F.A.C.P., F.C.A.P., 82 pp., Price $3.75, Grune & Stratton, Inc., 1954.

This is Number nine in the Modern Medical Monograph Series being published by Grune and Stratton. Since it is a syllabus it is short, concise and to the point.

There are no references, and no bibliography. As the author states in his preface "The present volume serves as a convenient introduction to the other volumes," and indeed, I would add, to the study of the Rh-Hr group of blood factors.

Leon E. Mermod, M.D.

### Internal Medicine.

Originally edited by John H. Musser, B.S., M.D., F.A.C.P., Fifth Edition edited by Michael G. Wohl, M.D., F.A.C.P., 1563 pp., illustrated, Price $15.00, Lea & Febiger, 1951.

The stated purpose of this 1,500 page book is to cover the field of internal medicine for the general practitioner and medical student. Its multiple contributors do a very good job of it. A particularly noteworthy feature is the general discussion of physiology, biochemistry, and pathology at the head of each section before the specific disease entities are taken up. The hundred page section on Endocrinology is very good. On the other hand, Allergy, a much more common problem, and collagen diseases, are lumped together into sixty-eight pages. While most of the important diseases are discussed at some length, many of the lesser ones are given only one to two paragraphs. The authors partly compensate for this shortcoming by a good bibliography with which the reader can supplement the information presented. This last shortcoming just highlights the difficulty in attempting to cover the field of internal medicine in 1500 pages. This book will provide a satisfactory source of information for most of the common problems encountered by the general practicioner in the field of internal medicine.

Raymond M. deHay, M.D.

### Salt and the Heart

By E. T. Yorke, M.D., 83 pp., Price $3.45, Drapkin Books, 1953.

Unfortunately, reviewing this book was not a pleasure. It seems to this reviewer that the book is neither on a high enough scientific level to appeal to physicians, nor on a low enough one to appeal to laymen.

However, there are several food tables which are useful in determining the sodium content of foods and occasional little known facts such as the point that most water softeners have a good deal of available sodium in them. In reviewing this book, I am inclined to quote the preface on page 6: "Everyone interested in the low sodium diet should obtain one of the excellent cook books on this diet, because the preparation of meals without salt challenges the genius of the average cook."

Alfred S. Hartwell, M.D.

### You and Your Skin.

By Norman R. Goldsmith, M.D., 148 pp., Price $3.75, Charles C. Thomas, 1954.

"You and Your Skin" is a small and a very easily readable book and should be read by every layman who had or has skin disease. The first three chapters would be extremely valuable to many doctors. Except for minor faults such as omitting the use of antibiotics in the treatment of tularemia, the length of the chapter on syphilis, and minor typographical errors, the book is very well edited and is well worth the price.

Nicholas Steuermann, M.D.

## Also Received

### School Health Service.

By Charles C. Wilson, M.D., 486 pp., Price $5.00, National Education Association and American Medical Association, 1953.

An important text for public health workers, educators and others interested in this subject.

### Coal Tar and Cutaneous Carcinogenesis in Industry.

By Frank C. Combes, M.D., 76 pp., illustrated, Price $2.75, Charles C. Thomas, 1954.

A valuable reference book for the industrial dermatologist.

### Retinal Circulation in Man and Animals.

By I. C. Michaelson, Ph.D. (Glas.), F.R.F.P.S. (Glas.), D.O.M.S. (Eng.), 146 pp., illustrated, Price $6.75, Charles C. Thomas, 1954.

Beautifully done and fascinating, but highly specialized.

### Thoughts About Life.

By Felix Friedberg, 40 pp., Price $2.50, Philosophical Library, 1954.

Punctuation is poor but the thoughts are deep and sometimes stimulating.

### Infrared Photography in Medicine.

By Leo C. Massopust, Sr., 53 pp., Price $2.75, Charles C. Thomas, 1952.

The official photographer of the Marquette University School of Medicine tells you all you could possibly need to know about this special and at times indispensable field of photography.

REPORT ON [redacted]

FROM A STUDY OF 97 HYPERTENSIVE PATIENTS[1]

EFFECTIVE ANTIHYPERTENSIVE

PRODUCT OF CIBA RESEARCH

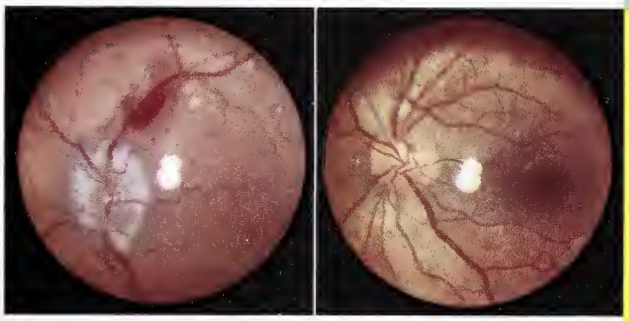


**APRESOLINE REDUCES DIASTOLIC PRESSURE**

Diastolic pressure reduced to level considered normal in one-quarter and to 110 mm. Hg or less in one-third of 97 patients receiving oral Apresoline for periods ranging from 3 months to 1 year or longer;[1] hypertension in which neurogenic or psychogenic mechanisms predominated most improved; patients with severe as well as moderate hypertension benefited.

**APRESOLINE LESSENS RETINAL ARTERIOLAR CONSTRICTION, RETINAL HEMORRHAGES***

Lessening of retinal arteriolar constriction; disappearance of retinal hemorrhages; remittance of hypertensive headaches, giddiness, paresthesias, transient pareses, and encephalopathies; some evidence of improved mental alacrity.





**APRESOLINE INCREASES RENAL BLOOD FLOW**

Renal improvement less marked than cerebral improvement, but renal blood flow and filtration rate increased and hematuria and proteinuria remitted in some cases; hypertensive heart disease little improved and, in some cases, worsened.

*Side Effects:* Side effects "minor, transient, or remediable" in most cases. Headache, gastrointestinal upset, periorbital and ankle edema, and a "grippe-like syndrome"—involving malaise and muscle and joint pain (see note)—observed.

# Apresoline®

**NOTE:** Appearance of arthritis-like symptoms during Apresoline therapy is an indication for cessation of treatment. Experience has shown that the phenomenon remits spontaneously on withdrawal of the drug. These symptoms are not likely to occur in patients who receive a daily dose of 400 mg. or less.

**FOR COMPLETE INFORMATION** on Apresoline ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J. **SUPPLIED:** Apresoline hydrochloride (hydralazine hydrochloride CIBA) 10-mg. tablets (yellow, double-scored), 25-mg. tablets (blue, coated), and 50-mg. tablets (pink, coated) in bottles of 100, 500, and 1000; 100-mg. tablets (orange, coated) in bottles of 100 and 1000.

1. TAYLOR, R. O., OUSTAN, H. P., CORCORAN, A. C., AND PAGE, I. H.: ARCH. INT. MED. 90:734 (DEC.) 1952.

*THE NORMAL FUNDUS (RIGHT) AS COMPARED WITH THE FUNDUS IN HYPERTENSION SHOWING EDEMA, EXUDATES, AND HEMORRHAGES (LEFT); ILLUSTRATIONS FROM "THE FUNDUS OF THE EYE": BEDELL, A. J.: CIBA CLINICAL SYMPOSIA 4:135 (JULY) 1952. THESE ILLUSTRATIONS ARE FOR DEMONSTRATION PURPOSES ONLY AND DO NOT REPRESENT APRESOLINE-TREATED PATIENTS.

CIBA



### ALLEVIATES HAY FEVER, OTHER RESPIRATORY ALLERGIES

The above photos show a case of allergic rhinitis before and after Pyribenzamine therapy. Many such cases have been reported in the literature. A few examples: Loveless and Dworin[1] found Pyribenzamine beneficial in 82% of 107 patients; Feinberg[2] noted relief in 82% of 254 cases; Gay and associates[3] in 76% of 51 cases; Arbesman and colleagues[4] in 84% of 106 cases. In a later study Arbesman[5] rated Pyribenzamine one of "the most effective of all the drugs studied in allergic rhinitis. . . ." *Side effects:* It has been stated that "undesirable symptoms from the use of 50 to 100 mg. doses of Pyribenzamine were rarely of sufficient severity to interfere with its use."[6] Drowsiness, nausea, epigastric distress, vertigo and other side effects—rarely severe—may occur in some patients.



### CONTROLS PENICILLIN REACTIONS

Pyribenzamine has been used successfully to control penicillin reactions—especially urticaria and itching. For example, Kesten[7] found that oral Pyribenzamine relieved or suppressed post-penicillin urticaria in 16 of 18 cases; she termed it "a most useful agent in allergic symptoms which follow the administration of antitoxin or penicillin."

### RELIEVES ALLERGIC DERMATOSES

Foster[8] reported good results with oral Pyribenzamine in patients with various allergic dermatoses. In another study[9] of 241 such patients, Pyribenzamine was found effective.

C I B A



*Pyribenzamine 25-mg. tablets now available— for children and for adults who can be maintained on low dosage or who experience side effects from the usual dosage of antihistamines*

*Supplied:* Pyribenzamine hydrochloride 25-mg. and 50-mg. tablets; Pyribenzamine Elixir, 30 mg. Pyribenzamine citrate (equivalent to 20 mg. tripelennamine hydrochloride) per 4-ml. teaspoonful; Pyribenzamine hydrochloride solution (for parenteral use), 25 mg. per ml., in 1-ml. ampuls.

PUBLISHED CLINICAL STUDIES SHOW THOUSANDS OF ALLERGIC PATIENTS RELIEVED BY

# Pyribenzamine®

PYRIBENZAMINE HYDROCHLORIDE (TRIPELENNAMINE HYDROCHLORIDE CIBA)
PYRIBENZAMINE CITRATE (TRIPELENNAMINE CITRATE CIBA)




**REFERENCES**

1. Loveless, M. H., and Dworin, M.: J. Am. M. Women's A. *4*:105 (March) 1949.
2. Feinberg, S. M.: J.A.M.A. *132*:702 (Nov. 23) 1946.
3. Gay, L. N., Landau, S. W., Carliner, P. E., Davidson, N. S., Furstenberg, F. F., Herman, N. B., Nelson, W. H., Parsons, J. W., and Winkenwerder, W. W.: Bull. Johns Hopkins Hosp. *83*:356 (Oct.) 1948.
4. Arbesman, C. E., Koepf, G. F., and Lenzner, A. R.: J. Allergy *17*:275 (Sept.) 1946.
5. Arbesman, C. E.: J. Allergy *19*:178 (May) 1948.
6. Feinberg, S. M., and Friedlaender, S.: Am. J. M. Sc. *213*:58 (Jan.) 1947.
7. Kesten, B. M.: Ann. Allergy *6*:408 (July-Aug.) 1948.
8. Foster, P. D.: California Med. *73*:413 (Nov.) 1950.
9. Morrow, G.: California Med. *69*:22 (July) 1948.


For complete information on Pyribenzamine ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J.

REPORT ON **Priscoline**

EFFECTIVE PERIPHERAL VASODILATOR

PRODUCT OF CIBA RESEARCH

**INCREASES PERIPHERAL BLOOD FLOW:**

Priscoline reported to be a valuable aid to conventional therapy in peripheral ischemia and its sequelae—pain, loss of function, ulceration, gangrene, other trophic manifestations; Priscoline most effective when vasospasm is prominent but may prove limb-saving even when vasospasm is minimal because it decreases vascular tone, promotes establishment of collateral circulation.

**MULTIPLE ACTION:**

Priscoline exerts direct vasodilating effect on vessel wall, blocks sympathetic nerves (probably at their terminations in vascular muscle), blocks vasoconstrictive action of circulating epinephrine-like substances.

*Side Effects:* Certain side effects of Priscoline—"crawling" cutaneous sensation, chilliness with resultant gooseflesh or feeling of warmth—indicate attainment of effective dosage level; occasionally tachycardia, tingling, nausea and epigastric distress, slight hypotensive effect or slight rise in blood pressure may be experienced.





**AGE 75.** Arteriosclerotic ulceration with erysipeloid reaction and marked inflammation; after administration of oral Priscoline, 25 mg. three times daily, for one week—increased thereafter to 50 mg. four times daily—there is steady improvement, healing in eight weeks. No other medication used.

# Priscoline®

**FOR COMPLETE INFORMATION** on Priscoline ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J. **SUPPLIED:** Priscoline hydrochloride (tolazoline hydrochloride CIBA) is available as 25-mg. tablets (scored), bottles of 100 and 1000; elixir, 25 mg. per 4 ml., in pints; 10-ml. multiple-dose vials, 25 mg. per ml.

Photographs and accompanying clinical data by courtesy of R. I. Lowenberg, M.D., Consultant in Vascular Surgery, Connecticut State Hospital, Middletown, Connecticut.





**AGE 68.** Arteriosclerosis obliterans cellulitis; sluggish response to saline dressings and procaine penicillin 300,000 units daily; healing speeded by oral Priscoline, 25 mg. four times daily for one week, 25 mg. every three hours thereafter; healing within six weeks.

# Blue Shield National Advertising Program

Beginning in the first week of April 1954, Blue Shield Plans across the nation herald the start of their first national program of public education. A program of national magazine space has been outlined in three publications that will enable Blue Shield to explain its unique qualities in the field of prepayment health care.

*Look* magazine will carry the first message for Blue Shield on April 6, and *Life* magazine will carry the second message on April 26. The *Saturday Evening Post* is the third magazine to be used in the campaign.

It was pointed out by Frank E. Smith, Director of the Blue Shield Commission, that Blue Shield is a unique organization. "The 77 Blue Shield Plans throughout the country and its territories are endorsed by medical societies in their respective localities. Each of them attempts to meet the medical needs in the area it serves," Smith said.

The Blue Shield messages will appear five times in *Life,* five times in the *Post,* and four times in *Look.* Combined circulation of the three magazines for any one issue is 71 million.

The need for bringing the Blue Shield story to the American public in some continuing, coordinated way has become increasingly evident. Imitators of the now famous Plans are confusing the public. "To be imitated is a sign of superiority, but when imitations begin to confuse and misdirect, then clarification is necessary," said Smith.

It was explained that Blue Shield was organized primarily as community service and not as a commercial venture, and that it is dedicated to serving the American people and fulfilling a social purpose. The programs of national education will attempt to point this out.

A fortress of conviction can be built in readers' minds to help them properly evaluate the welter of promises being made today in the hospital and medical protection marketplace. Space in national publications gives Blue Shield the latitude necessary for its story, as well as affording the Plans the most effective and practical way to educate their present members and prospective members. Logically, if members really understand what their membership means, they will make a greater effort to retain it. At a cost far less than that offered by any other method, the new means of education will contact these members regularly in their homes. Wives as well as husbands will be exposed to the meaning of belonging to Blue Shield.

Through its choice of media, Blue Shield will speak to a large and significant audience. In combination, *Life, Look,* and the *Post* will reach about 60 per cent of the executive group in America, the proprietors of businesses, professional men and top-level executives. They also will reach about 60 per cent of the white collar group, salesmen, and people in clerical and office jobs. They will reach 35 per cent of craftsmen, foremen, machine operators and non-farm laborers. Thirty-five per cent of service workers and 32 per cent of farmers and farm laborers will also be reached. No other combination of national publications could offer this range.

While the practicality of Blue Shield needs public *telling,* it needs no further proving. The record of service speaks for itself. Last year, the 77 Blue Shield Plans provided over *260 million dollars* in benefits. And all this was handled *locally* on each Plan's level. Blue Shield, though it is nationwide, is an association of autonomous Plans sponsored in the areas served by the citizens, the hospitals, and doctors. Each Plan exists only for the benefit of the people in its own area. Dues and benefits are determined locally to fit local needs and conditions. All money paid in by those who belong to a Plan, except for the small amount needed for administrative expense, is set aside to pay for care.

Blue Shield has a magnificent story to tell the American public, a story of typical American growth in a voluntary, community enterprise. In April millions who have Blue Shield, and millions who have merely heard of the organization will begin to get the first-hand story of the Plan.

HMSA is your Blue Shield Plan for Hawaii.

# County Society Reports

## Hawaii

A dinner meeting of the Hawaii County Medical Society was held on Thursday, January 28, at 6:30 p.m. at Hilo Hotel. Members present were: Doctors Bergin, Carter, M. H. Chang, Crawford, Haraguchi, Hayashi, Henderson, Jenkin, Knotts, Loo, Matsumura, Mitchel, Miyamoto, Okumoto, Orenstein, Ota, Oto, Paynter, Stemmermann, Steuermann, Wong, Woo, Richard Yamanoha, Yuen, Gray, Oakley, Rothrock. Guests present were: Doctors Archer, Todt, and the three internes from the Hilo Memorial Hospital.

Dr. Steuermann, by referring to the last meeting of the Advisory Health Committee, asked the members of the Society to pass a resolution regarding the choice of surgeons for medical indigents and welfare cases. Dr. M. H. Chang moved and seconded by Dr. Bergin that the present panel of surgeons should be continued and the choice of surgeon to be called in for medical indigents and welfare cases should be left to the discretion of the individual physician. Motion was carried.

Dr. Crawford reported that during the last Maternal and Child Health conference held in Honolulu, it was pointed out that on Oahu there is an auditory survey of school children which services have been extended to all the islands. Dr. Crawford reported that the Board of Health has asked for the cooperation of the Hawaii County Medical Society on this problem. Dr. Wong moved and seconded by Dr. Woo that the Hawaii County Medical Society endorses the Board of Health auditory survey of school children.

Mr. James Carroll, local representative of the HMSA reported on the progress of HMSA on the Island of Hawaii in 1953.

After dinner Dr. Maurice Grier gave a very interesting talk on Post-partum Care of the Cervix followed by a short movie on Pudendal Block Anesthesia in Delivery.

* * *

A scientific dinner meeting of the Hawaii County Medical Society was held on Tuesday, February 9, 1954. Members present were: Doctors Bergin, Hayashi, Kasamoto, Kutsunai, Leslie, Miyamoto, Okumoto, Stemmermann, Steuermann, Yuen, Rothrock. Guests present were: Dr. E. K. Shelton, Professor of Endocrinology at U.C.L.A.; and Dr. Jack C. Todt of K.M.C.

A lecture by Dr. Shelton was heard by the members.

* * *

The annual meeting of the Hawaii County Medical Society was called to order by Dr. Chisato Hayashi, President of the Society, at 6:30 p.m. March 25, 1954, at the Izumoto Tea House. Members present were: Doctors Bergin, M. H. Chang, M. L. Chang, Crawford, Hayashi, Henderson, Jenkin, Kasamoto, Kutsunai, Loo, Mitchel, Miyamoto, Okumoto, Orenstein, Ota, Paynter, Stemmermann, Steuermann, Tomoguchi, Wong, Woo, Richard Yamanoha, Yuen, and Rothrock. Guests present were: Dr. Edwin K. Chung-Hoon, President of the Hawaii Medical Association; Dr. Robert Faus, Medical Director of the Hawaii Medical Service Association; Mr. Albert Yuen, Statistician of the Hawaii Medical Service Association; and the four internes from the Hilo Memorial Hospital.

Dr. Kasamoto, Chairman of the Nominating Committee, presented the following names for officers of the Hawaii County Medical Society for 1954-1955:

| | |
|---|---|
| *President* | Dr. Toshio Kutsunai |
| *Vice President* | Dr. Nicholas Steuermann |
| *Secretary* | Dr. Grant N. Stemmermann |
| *Treasurer* | Dr. James A. Mitchel |
| *Delegates* | Dr. T. D. Woo |
| | Dr. Chisato Hayashi |
| *Alternates* | Dr. Edward Wong |
| | Dr. H. E. Crawford |
| *Board of Directors* | Dr. John T. Jenkin (term to expire 1955) |
| | Dr. S. Kasamoto (term to expire 1956) |
| | Dr. S. M. Haraguchi (term to expire 1957) |

The report of the nominating committee was unanimously accepted by the membership.

Dr. Robert Faus and Mr. Albert Yuen gave a report on HMSA's activities of 1953.

Finally, Dr. Chung-Hoon, President of the Hawaii Medical Association, gave the president's address.

Nicholas Steuermann, M.D., *Secretary*

## Maui

A special breakfast meeting of the Maui County Medical Society was held at the Central Maui Memorial Hospital on Sunday, January 24, 1954.

Those in attendance were: Drs. Ohata, Kashiwa, Tompkins, Ferkany, Cole, Sanders, Shimokawa, Izumi, Fleming, Kanda, St. Sure, Patterson, Burden, Underwood and A. Y. Wong. Guests were Drs. Rose, Boyd, Henry and Capt. King.

It was decided to accept the request of the Honolulu Heart Association and have a meeting in April to devote to this subject.

The Society also favored the request of Dr. Dodge to hold orthopedic clinics more frequently provided the scheduled dates can be decided in advance.

The rest of the meeting was given over to Dr. Henry and Capt. King who gave an excellent symposium on X-ray interpretations of the gastro-intestinal tract. The discussions were supplemented with numerous films, with stress on routine gastro-intestinal examinations.

* * *

The regular meeting of the Maui County Medical Society was held at the Central Maui Memorial Hospital on the evening of March 9, 1954.

Those in attendance were: Drs. Rockett, Kashiwa, Izumi, Tofukuji, A. Y. Wong, St. Sure, Patterson, Sanders, Shimokawa, Mar, Fleming, McArthur, Kanda, Haywood, Underwood, Burden, Tompkins, Ferkany, Ohata, Cole and H. Kushi. Guests were: Drs. Boyd, Mei, McPheeters, Cowan from Edmonton, Canada, and Angie Connor.

Requests from the Heart Association and the Advisory Committee to the Bureau of Maternal and Child Health to hold meetings with the Medical Society in April were brought up for discussion. Since only one meeting was scheduled for April, it was decided to leave the decision with the Program Committee as to which request should be honored.

The Nomination Committee made its report and the following officers were elected unanimously for the fiscal year 1954-55.

| | |
|---|---|
| *President:* | Harold S. Kushi |
| *Vice-President:* | James F. Fleming |
| *Secretary-Treasurer:* | Louis S. Rockett |

Dr. A. Connor gave a brief summary of a method of screening patients for the Child Welfare Clinic. She also suggested an audiometric check of all pre-school age group patients and those below the 4th grade level that attend the clinic or sent by doctors for the specific test. Experience in Honolulu has shown approximately 4-6% of those examined showed definite hearing loss. Both recommendations were well received and follow-up studies were planned.

The rest of the meeting was turned over to Dr. McPheeters of Minneapolis, Minnesota, who gave the Society one of the best presentations on the subject of diagnosis and treatment of Varicose Veins. His talk was illustrated with slides and motion pictures. Discussion followed the talk and ended with a demonstration on a patient with varicose veins, the technique and evaluation of the various tests used.

HAROLD S. KUSHI, M.D.
*Secretary-Treasurer*

## Kauai

The regular meeting of the Kauai County Medical Society was held on February 9, 1954 at the G. N. Wilcox Memorial Hospital medical library. The meeting was called to order by Dr. Ishii at 7:45 P.M. Members present were Drs. Wallis, Masunaga, Cockett, Kim, Goodhue, Fujii, and Yamauchi.

The following members were nominated by the majority of the Board of Censors for offices:

President.....Dr. Peter Kim
Vice President.....Dr. Richard Yamauchi
Secretary-Treasurer.....Dr. Sam Wallis, Dr. Burt Wade, Dr. Webster Boyden

A letter from Dr. West, Chairman, HMSA Medical Committee, regarding HMSA Medical Committee meeting held on January 15, 1954, pointed out that many doctors are providing claims forms directly to management or Union representatives rather than to the Insurance Carrier, and that by such procedure the doctors are divulging medical information without proper authorization and are, consequently, subjecting themselves to possible lawsuits.

RICHARD M. YAMAUCHI, M.D.
*Secretary*

* * *

The regular monthly meeting of the Kauai County Medical Society was held March 9, 1954 at 7:30 P.M., Dr. Clyde Ishii presiding.

Members present: Doctors Kim, Cockett, Wallis, Ishii, Yamauchi, Goodhue, Masunaga, Fujii, Boyden, Wade and Brennecke.

Minutes of the February meeting were read and approved after which the annual election of officers was held, the following being elected:

*President*—DR. PETER KIM
*Vice President*—DR. RICHARD YAMAUCHI
*Secretary-Treasurer*—DR. WEBSTER BOYDEN
*Delegate*—DR. PATRICK COCKETT
*Alternate*—DR. SAM WALLIS
*Censor, 3 year term*—DR. CLYDE ISHII

Communications were read from Mrs. Bennett regarding the Post AMA Convention Tour to Hawaii and from Dr. Connor acknowledging our letter in which we had decided to accept temporarily, the Honolulu Means Test for eligibility for free services to child health conferences.

Mr. Veltmann and Dr. Faus of the HMSA and Mrs. Hilda Inouye, local branch manager, were present as guests. Mr. Veltmann and Dr. Faus reported on the 1953 operations of the association. Despite competition from mainland concerns, the organization has shown additional growth and members now constitute 15% of the Territory's population.

* * *

President Peter Kim of the County Medical Society called the meeting to order at 8:15 P.M. on March 18, 1954 at the Kauai Inn Banquet Room. Members present were. Drs. Sam R. Wallis, Patrick M. Cockett, Webster Boyden, Kenneth Fujii, Eichi Masunaga, and William Goodhue.

Guests present were: Drs. W. Terrell Simpson, Eugene H. Countiss, James K. Fancher, William E. Fountain, Herbert L. Harvey, Charles Hightower, Walter J. Jones, Otis E. Marler, H. J. Setzer, D. Battaglia, Russell F. Weyher, M. A. Sonderegger, W. J. Wilson, and Harry Murray, all of the New Orleans Post-Graduate Medical Assembly. Dr. E. Strongman of the Wilcox Hospital residency staff was also present as a local guest.

The program as drawn up by the committee consisted of the following:

DR. SAM R. WALLIS—*Rural Medicine in Hawaii.*
DR. R. F. WEYHER—*Myxedema Heart Disease.*
DR. C. C. HIGHTOWER, SR.—*Goiter and Surgical Treatment of Last 300 Cases.*
DR. D. BOTTAGLIA—*Diagnosis and Management of Common Types of Clinical Asphyxia.*
DR. W. E. FOUNTAIN—*Coins and Medals Relating to Medicine.*

The group of visiting doctors and their wives was entertained by our Society the evening of March 17 at the home of Dr. and Mrs. Sam Wallis. Cocktails and dinner were served.

Dr. Cockett acted as chairman of the entertainment program, which in addition to the above, included sightseeing trips on Kauai.

WEBSTER BOYDEN, M.D.
*Secretary-Treasurer*

## Honolulu

The regular monthly meeting of the Society was held in the Mabel Smyth Auditorium on Friday, March 5 at 8:00 P.M. Dr. William S. Ito presided and approximately 100 members and guests attended.

Dr. John Elliott from Miami, Florida presented a paper on the subject of "Blood Transfusion Reactions with Special Reference to Immunology."

Dr. H. O. McPheeters from Minneapolis, presented a paper and his own film on "The Treatment of Varicose Veins."

Mr. Kennedy then read the proposed amendments and revisions to the Society's Constitution and By-Laws which were approved by the Board of Governors on February 23.

Dr. Robert B. Faus, Medical Director of HMSA, reported on national and local trends affecting the practice of medicine.

Upon adjournment at 10:15 P.M., the members joined the Woman's Auxiliary for refreshments.

R. C. DURANT, M.D., *Secretary*

* * *

The annual meeting of the Honolulu County Medical Society and the Honolulu County Medical Library was held on Friday, April 2 at 8:00 P.M. in the Mabel Smyth Auditorium. Dr. William S. Ito presided and approximately 75 members attended.

The Committee on Communicable Disease Control of the Territorial Civil Defense Agency requested the

Medical Association's consideration of a voluntary program of active immunization against tetanus. This matter was then referred to the Board of Governors who approved the program and recommended that a fee of $1.00 per injection be set during the campaign.

Dr. Chung-Hoon's motion approving the program of voluntary immunization against tetanus was adopted by the Society.

The question of establishing a fee for each injection during the campaign was debated extensively. Thereupon, by majority vote, a fee of $2.00 per injection was adopted.

Dr. Walter Quisenberry, Chairman of the Steering Committee of the post-AMA convention tour to Hawaii, outlined plans concerning local arrangements. The tour has been widely publicized throughout the mainland and it is expected that 600 doctors and wives will attend. This convention will be considered the summer meeting of the Hawaii Medical Association.

Dr. Ito presented a resolution, formulated by the medical library's governing board, and approved by the Society's Board of Governors, pertaining to the establishment of a rent free policy for the Library.

The committee reports, on motions duly made and carried, were approved and placed on file.

It was moved, seconded and carried that the County Society request that this year's annual reports be published in the HAWAII MEDICAL JOURNAL.

The report of the Nominating Committee was read and adequate opportunity was given for nominations from the floor. Election was by secret ballot and the Secretary was instructed to cast a unanimous ballot for those positions having no competition.

The following were elected:

DR. C. M. BURGESS, *President*
DR. RICHARD C. DURANT, *Vice President*
DR. J. M. FELIX, *Secretary*
DR. TORU NISHIGAYA, *Treasurer*
*Board of Governors* (for 2 years)
DR. ROBERT F. BAILEY
DR. B. ALLEN RICHARDSON
DR. LAURENCE M. WIIG
*Alternate Governors* (for 1 year)
DR. JOHN P. FRAZER
DR. CLIFFORD K. KOBAYASHI
DR. FRANCIS T. KANESHIRO
*Delegates to Hawaii Medical Association* (for 2 years)
DR. JOHN L. BELL
DR. E. F. CUSHNIE
DR. JOHN WM. DEVEREUX
DR. WILLIAM S. ITO
DR. HAROLD M. JOHNSON
DR. JOHN J. LOWREY
DR. MASATO MITSUDA
*Alternate Delegates to Hawaii Medical Association* (for 2 years)
DR. SAMUEL D. ALLISON
DR. LYLE BACHMAN
DR. RAYMOND DEHAY
DR. ALBERT H. ISHII
DR. ANDREW L. MORGAN
DR. DORIAN PASKOWITZ
DR. WILLIAM H. STEVENS
*Representatives to HMSA* (for 2 years)
DR. E. K. CHUNG-HOON
DR. LAURENCE M. WIIG
DR. SAMUEL L. YEE
*Board of Censors* (for 3 years)
DR. WM. M. WALSH
*Committee on Forms of Medical Practice* (for 5 years)
DR. WM. S. ITO
*Fee Adjustment Committee* (for 3 years)
DR. FREDERICK L. GILES
DR. HOMER M. IZUMI
*Library Board of Governors* (for 3 years)
DR. HENRY C. GOTSHALK
DR. O. D. PINKERTON
DR. C. Y. SUGIHARA
DR. DEAN M. WALKER

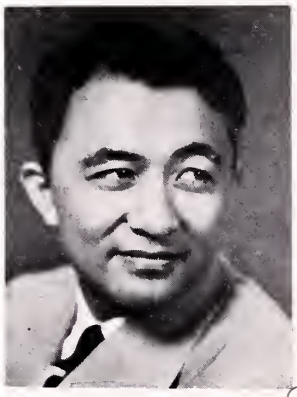
After a brief message by the new President, Dr. C. M. Burgess, the meeting adjourned at 11:15 P.M. for refreshments on the lanai.

J. M. FELIX, M.D., *Secretary*

**PRESIDENTIAL ADDRESS**

**William S. Ito, M.D.**

Ten years ago I had not decided where I would go to practice medicine. Ten years ago, as a member of the armed forces, I had no idea nor thought that one day I would be the president of the Honolulu County Medical Society. Yet tonight, the time has come to end my sixth year of service in this society and to retire from the office of the president with the hope that I carried the responsibilities with dignity, not only of a physician but also of the office which represents the medical profession of Honolulu. Before turning over the gavel to my successor, I thank all of you for the high honor you bestowed upon me in April 1953. The year has been an education for me; and if I have been fortunate enough to have served with a minimum of failure, then the degree of success has been proportional to the degree of cooperation from the members of this medical fraternity.



DR. ITO

I have many many people to thank: my fellow officers, my Board of Governors; my committee-men; the president of HMA and my many friends who advised so wisely behind the scenes. I have praise and sincere thanks for the very good work done by the society's secretary, Mrs. Jeanne Detor. Believe me, her contribution was great. You have heard the annual reports submitted by the chairmen of the all-important standing committees. I shall not discuss them nor review them, as important as they are. I shall express my sincere gratitude by saying simply, "thank you for work well done" and ask the new officers to study the recommendations carefully. I could not, however, retire from office without thanking at this time the members of the temporary special committees appointed to meet immediate problems and who have not had the opportunity of reporting to you tonight.

To the Executive Secretary, Mr. Richard Kennedy, I bring not only the gratitude of my office, but also the appreciation of the entire medical society for bravely embarking upon a new venture which is now established successfully as the Bureau of Medical Economics. Absolutely no doubt exists about there being a need and a place for this bureau in our profession and in the society's program. This Bureau has earned its right to exist and deserves greater support from each and every one of you. The details of organizing this department were probably more tedious and more discouraging at its inception than any phase of the function of the president assuming a previously organized office. The development of a medical credit list and a successful collection agency has gotten an auspicious start. Mr. Kennedy, along with the Public Service Committee, has the duty to sell the doctors to the public. He will in all probability not only speak of the availability of physicians' services in this community but he will emphasize the quality and cost. Let us all help him by making a man's right to go to the doctor of his own choice more attractive. That you can do by providing more personal attention, and better health services per dollar.

The committees' annual reports have shown that a great deal was accomplished during the past year, much of it not without a bit of swearing and sweating. My experience reveals that to look ahead a year or two is inadequate. We must set our sights high and think in terms of five, or better ten, years ahead. Upon assuming the presidency, I was warned by the past officers, "get busy now because in a few days your year will be over." How true it was! I hope in 1964 the president of your society will be able to speak happily of free enterprise, fee-for-service, and free choice of physicians. The subject of socialized medicine has been talked into the ground but I'd like to revive the subject for a few minutes this evening lest its ghost haunt us in our failure.

I was initiated into the presidency by having tossed into my lap a hot potato which seared upon me an impression I shall never forget. It came in form of House Bill 692.

Free choice of physicians is one of the strong foundations upon which stands a cherished institution known as American Medicine, including the freedom and the right to pursue private practice of medicine. With it comes man's privilege of choosing his physician and that privilege must extend to all phases of medicine whether it be private and personal or industrial. Let us not be led to believe, as some would wish it, that free choice of physicians is old-fashioned, and that that right should be placed in the hands of a second party whose motives are not clear to the ill, the injured, nor the physician. The principle of free choice of doctors should always be an intergral part of Americanism in medicine.

However, let us study critically labor's interest in HB 692 and free choice of physicians. Experience has shown that many labor unions have no interest except in that which is advantageous to themselves. Labor's interest in legislation of this kind, then, should be viewed with skepticism, and perhaps it should serve as a warning to the profession. It was their failure to force upon the nation a National Health Law that has prompted them to turn to industrial health benefits as a means to that end. All of you know that the Weinerman Report to ILWU clearly and undeniably stated that a compulsory national health law is the ultimate goal. The clamor for socialized medicine across the continent has seemingly subsided with the change of government administration. This lull is merely exertional dyspnea. When the breath returns, there will also return, perhaps cloaked under a different name, a deliberate, calculated, vociferous campaign for complete and total medical coverage. There will be demands that the federal government be the provider of good health. Complete medical coverage by compulsion, as all of you well know, is not insurance but taxation, and it will lead to a state equivalent to complete medical indigence of the entire population.

Scattered isolated interest by labor in medical care as a fringe benefit has rapidly snowballed into a demand for comprehensive medical care programs for all union members and their dependents, threatening if necessary to set up their own clinics and hospitals. This trend will force the medical profession to make drastic changes in the very nature of medical practice. The time has come when we can no longer discuss medical care for industrial accidents as being separate from and unrelated to care for non-industrial illness and accidents. Labor unions' interest in free choice of physicians must be looked upon as their search for a means by which free choice can be lifted from the hands of the employees and be placed into the control of unions by the same type of pressure that has forced unwilling employees to strike when a strike is thought to be desirable by the union leaders. Once this occurs, union-controlled panel medicine will have taken root in the community and complete socialization of medicine will be that much closer to reality.

The medical profession's weakness seems to be its unwillingness to do anything until pressure is of such magnitude that freedom of practice is endangered. It is necessary that this profession of ours continue to offer a plan satisfactorily constructed within the framework of free enterprise and preserving such advantages as fee-for-service, and free choice of physicians. Your plan is the Hawaii Medical Service Association, a modified service plan in which the doctors still have considerable voice as to fees and administration. During the past year several new commercial insurance companies have come into the territory. These companies are providing health and accident indemnity plans, painted rosy for the union by underbidding HMSA at the risk of local losses for the sake of experience.

The significant danger in the union contracts with these commercial carriers is the fact that these plans are carefully policed not by the carriers but by the unions, and the physicians' reports and statements are carefully screened by the same group. The unions know today how much is being charged by each doctor. Many of you are aware of the fact that some insurance checks for $3.00 per office visit are now being sent directly to the doctor's office, perhaps hoping that the dollar or two balance will be a nuisance to collect, at the cost of 25c per statement per month. They want your office visit to come down to a flat $3.00 per visit. If you charge over the indemnity fee schedule, they yell "foul." It is known that, strangely enough, some of the very same men who in May 1953 screamed about union control of "choice of physician" are settling for indemnity fee schedule as full payment of their fees.

The point I wish to make is that in this "cold war," the doctors are plenty snafu. Because there is a difference between service benefits and indemnity dollars, the medical care insurance program in Hawaii should not be primarily a branch of the commercial insurance industry through which labor squeezes the medical profession, but rather should be a non-profit plan sponsored by the physicians in cooperation with the general public.

In this political war for preservation of American Medicine, the doctors must have the weapon in their hands, and that weapon must be a "Unified Front." Although the physicians work and think as individuals and thank God, remain one of the most ruggedly individualistic groups in the community, there must be similarity of thought on major issues which jeopardize their individualism. Representatives of press and radio, representatives of insurance carriers, and of industry have often remarked that doctors are not able to agree on vital issues. Now labor is finding it not difficult to weaken the structure of private practice of medicine by tearing apart such vital components as fee-for-service. The sick will be cared for by methods dictated by labor and government unless the physicians show greater cooperative thinking and cooperative action. A singleness of purpose and a united opinion must take the place of internal strife which leads a situation of who can insult whom in the most obstreperous manner in public. Holding foremost in our minds that any plan or program or any change in our system of practice of medicine must be for the purpose of improving medical

care of our patients, let us learn to speak as one, and together, learn to become politically wiser.

The progress of medicine, as you know it, ranging from decrease in fetal and infant mortality to the increase of 20 years to the life span of the average citizen of our country, was made without socialized medicine. You do not need any form of medicine controlled by union or government! Ten years from today I want to be able to say that my family and your family have free choice of physicians and that the quality of medical care that they receive is not dependent upon political favors or union membership. I sincerely hope that in 1964 the advocates of government medicine will be sad, discouraged, and long-faced.

Thank you, and Aloha!

**SECRETARY'S REPORT**

**Richard C. Durant, M.D.**

The end of the last fiscal year of the Society fell on February 28, 1954. At this time the total membership consisted of 435 doctors—a net gain of three during the year. The distribution is as follows:

| | |
|---|---|
| Life Members | 9 |
| Regular Members | 335 |
| Retired Members | 4 |
| Honorary Members | 11 |
| Associate Members | 76 |
| Total | 435 |

The special meeting on May 11, 1953 was called to consider House Bill No. 692 relating to Workmen's Compensation and amendments affecting free choice of physicians thereunder. A motion to approve the bill and urge passage by the Senate was carried by a close vote. The bill subsequently failed to become law by pocket veto of the Governor of Hawaii. A special committee, including representatives of the Medical Society, has been appointed by the Governor to study and work out ways of compromising conflicting view points of the affected parties.

The Board of Governors held 11 regular and 3 special meetings during the year, including one instructional meeting with the Delegates and Alternates to the H.M.A. Many hours were devoted to problems of HMSA both in regular and special meetings. Insurance carriers were given an opportunity to discuss premium rates on malpractice insurance. Amendments to the Constitution and By-Laws have been drawn up for approval of the Society. These include such far-reaching changes as ending the fiscal year on December 31; telescoping overlapping functions of certain committees and creating new committees to deal with new functions not previously covered. Much time has been spent looking towards a solution of financial and other problems relating to the Mabel Smyth Building, and the current outlook is encouraging. Close, friendly liaison with many community organizations, such as the Board of Health, has been maintained throughout the year.

Postgraduate lectures by Dr. Ian MacDonald, Department of Surgery, U.S.C., were enthusiastically received. Thanks again are due the Hawaii Cancer Society for underwriting expenses connected with his trip.

**TREASURER'S REPORT**

**John M. Felix, M.D.**

This year saw an increase in dues from $85 to $95 per year, in order to support our own postgraduate lectures in the future, to pay the increased rental for space occupied by the Society in the building, and to help replenish our depleted reserve.

We have also instituted a more realistic method of supporting our library. Hereafter the library will receive $27 for each regular member of the Society, and $13.50 fo each institutional member, amounting to approximately $8,000 per year. This method of transferring funds will relieve the library of the necessity of presenting their annual budget and request for funds to the Society. Annual dues to the Hawaii Medical Association have been paid by this method for several years.

In the forthcoming fiscal year, of the $95 paid by each member in dues, 29% will go to the Honolulu County Medical Library, 27% to the Territorial Medical Association, and 44% for the direct expenditures of the Society.

A review of our audit reveals an increase in reserves of approximately $2,000 during the past year, bringing the general fund to $23,765. This can be attributed to the substantial savings in budgeted expenses, an increase in general membership and an unexpected accumulated interest on matured bonds.

Our auditor, Mr. Frank H. Leman, has expressed a high regard for the staff of the Medical Society in that the standards of accounting have been upheld and that our books and finances are in excellent condition.

**BUREAU OF MEDICAL ECONOMICS, LTD.**

**R. M. Kennedy**

Your Bureau of Medical Economics has been operating for five months, and is going full steam. The Society through the Public Service Committee made arrangements to have $16,000 available for operating expenses, $6,000 from the Society, and $10,000 from the membership in the form of a two year loan. The $6,000 from the Society was used to incorporate and we put $5,000 in Bureau stock, while the remaining $1,000 is recorded in the Bureau's books as a loan payable. To this date we have received $7,550 in loans from the membership and I have estimated that all loans promised would be in by May 1 of this year.

Most of our operating expenses were based on the experience of the Santa Clara County's collection bureau, which has a membership of about 400 doctors to our 346. We estimated that during the first year, we would receive approximately $160,000 in assignments. At the end of five months we should have had $67,000 assigned. *We actually have received over $82,000 in assignments.*

Our budget indicated that we would spend $15,500 in our first year. This includes a little over $2,000 in non-recurring expenses. After five months, our expenses should have been about $7,600. We have actually spent $7,200. As you can see, we are keeping within the budget.

Now how are we doing with respect to collections? It was visualized that we would receive in the first twelve months a lot of old accounts and all the "deadbeats," and therefore it was estimated that we would only collect 25% of the assignments. I figured that at the end of three months we would have a steady flow of collections coming in. The total collections, after five months of operation, are running several hundred dollars ahead of original estimates. During February and March, our fouth and fifth months, we showed a profit.

One hundred seventeen doctors are now using the Bureau. (This includes all the doctors in the Straub Clinic and the Medical Group.) We are now serving 35% of the membership, but I feel certain that at the end of our first year we will be serving over 67%.

Our files have over 2,000 individual accounts, and of course many multiple accounts. The information in these files is one of our greatest assets, and its value grows daily. This information is available to you at all times. We are making hundreds of personal contacts with your patients, and in most cases they go away feeling better than when they came in. In many cases we have been able to help the indigent, and I think this is very important. We consistently state in letters, personal contacts and public occasions, "NO PERSON OR PERSONS WILL GO WITHOUT MEDICAL CARE BECAUSE OF INABILITY TO PAY. THE DOCTORS OF HONOLULU GUARANTEE THIS THROUGH THE BUREAU OF MEDICAL ECONOMICS." We have even broadcast this statement on the radio.

The Society should give a hearty thanks to its outgoing Public Service Committee for the time and effort spent in organizing the Bureau.

The greatest difficulty in tracing accounts is the lack of middle initials, husband's name, and place of employment. This information is of utmost importance. When you have mail returned, and cannot obtain a forwarding address—don't hold the account! The sooner we receive it after the patient has moved, the better the chances are of finding him.

Our records show a drop in value on your accounts at 6 months, and then the biggest drop of all comes when the account goes over 12 months. Don't hold them over a year. Don't let these commercial collectors give you a line about the Bureau. If they tell you something detrimental about the Bureau, phone me and I will try and straighten the matter out then and there.

I am looking forward to serving the entire membership, and if I can be of any help in your collection work or public relations, you need but call my office.

**BOARD OF CENSORS**

**Rogers Lee Hill, M.D.**

The Board of Censors performed the routine duties of office during 1953-54 in the customary manner.

An investigation was made concerning charges preferred against two members for unethical advertising. No action was deemed necessary and a report with these conclusions was made to your Board of Governors.

**EMERGENCY MEDICAL SERVICE COMMITTEE**

**Robert B. Faus, M.D.**

During the past year the following officers have reported for active duty:

Capt. C. A. Domzalski
Lt. Edward C. Wo Lum
Capt. Richard Noda
Major Harry K. Takenaka

Released from active duty during the year were the following:

Dr. Richard E. Ando
Dr. Clifford T. Druecker
Dr. Yasuyuki Fukushima
Dr. Andrew C. Ivy
Dr. Joseph T. Lucas, Jr.
Dr. Donald G. Rumer
Dr. Ernesto Santos
Dr. Francis K. H. Won
Dr. Richard Y. K. Wong

We have carefully processed all physicians entering the service in order that they might be called in proper order. We have tried to welcome the doctors on their return, offering them assistance in finding or reestablishing a practice.

Since there have been no calls from Selective Service for physicians since last summer, the committee did not meet until March 1954, nor did we ask for deferments.

Only one physician has refused to enter the service. He was a Canadian citizen, but renounced his application for U. S. citizenship in order that he might leave our country.

At our request the Selective Service System in Washington, D. C. authorized its local office to purchase for us a Key Sort System with which we are recording and maintaining a complete file of all physicians in Hawaii.

Dr. West and Dr. Quisenberry represented Hawaii at the June 1953 meeting in New York City of the Medical Advisory Board of the Selective Service Department.

The Chairman has participated in all civil defense exercises from Eversharp 1 through 5. Most of them have been high level command post exercises.

The arrival of certain amounts of medical supplies, the Territory's appropriation of $250,000 and an additional $250,000 from Federal funds, have enabled us to stockpile 20 one-thousand-casualty units of supply, which consist of drugs, dressings, instruments, blood substitutes and donor sets. In addition, the federal government has provided an additional 10 one-thousand units of similar supplies for federal stockpiling in Hawaii. These would be available to any area in the Pacific where the federal government might direct their use. Antibiotics subject to deterioration are constantly kept fresh by rotation. This is all under the direction of the Board of Health. Dr. Richard K. C. Lee has designated Dr. Jerome Rosengard to sort out and stockpile properly these vast supplies with a locator file at three different areas: Board of Health, Civil Defense headquarters, and at the tunnel itself. There is a constant inventory maintained of all materiel.

The Blood Bank reports that its emergency unit is ready for immediate operation at the turn of a switch. More than 100 individuals on the Island of Oahu have been trained by the Blood bank in connection with concentrated Civil Defense plans.

Governor Val Peterson, Federal Civil Defense Agency Administrator, was kind enough to appear before this committee on March 30, 1954 at our invitation. He graphically presented the possibilities of thermonuclear destruction, which might be estimated in millions of kilo ton units. It thus becomes apparent that a committee such as ours should continue its function with renewed zeal and effort. In view of President Eisenhower's warning to the nation that we will continue to remain in jeopardy of attack for some time, it behooves us to strengthen our preparedness program by training and exercises in order that any plan for evacuation of areas or the care of casualties in event of disaster, either natural or man-made, might be orderly and proficient.

We are presently revising assignments and bringing them up to date in order that every physician may be summoned to his respective point of duty to function in the capacity in which he is best trained to serve. We urge your immediate attention to these assignments when circulated. If any correction or change is necessary, consult promptly with the medical director of the hospital. Doctors assigned to aid stations should confer immediately with Dr. Mossman or his personnel officer for any change or reassignment.

We are glad to serve the Medical Society in this difficult capacity and are willing to continue the purposes and functions of this committee if you so desire. We would recommend that Dr. Isaac Kawasaki, our first alternate, be designated by the Society as a full member of the committee, replacing Dr. Steele Stewart, who is no longer a member of the Medical Society.

## FEE ADJUSTMENT COMMITTEE

**H. McLeod Patterson, M.D.**

The Fee Adjustment Committee, composed of Drs. Clifford K. Kobayashi, Tadao Hata, B. Allen Richardson, Laurence M. Wiig, Dean M. Walker, and H. McLeod Patterson, met throughout the year as the need arose. Due to the enormous amount of work done by past committees, very few meetings were necessary.

The Industrial Accident Fee Schedule and the HMSA Fee Schedule were amended and copies circulated to all physicians. Very few inquiries or complaints have been routed to this committee, indicating a general acceptance of our work. A few physicians have expressed general disagreement, but that is to be expected when a Committee is suggesting what they charge their patients for services rendered.

If this feeling is general, the Fee Adjustment Committee should be dismissed, but until such time, the present elected members will continue to do the work assigned them.

## GRIEVANCE COMMITTEE

**Wm. M. Walsh, M.D.**

During the year, the Grievance Committee was called upon for recommendations regarding a number of differences between doctors and patients, as well as charges preferred by insurance carriers against physicians.

The differences between the individual doctors and their patients were settled amicably to the satisfaction of both parties in practically all instances. However, while the requests for investigation by insurance carriers were settled, it is my firm belief that the entire machinery of investigating complaints, recommending disciplinary action and carrying it out is in need of a complete revision.

Therefore I should like to recommend that the incoming officers of the Medical Society make every effort to carry through the plan as presented by Mr. Kennedy at our March Membership Meeting. This plan, if approved, would consolidate the activities of the Grievance Committee, the Committee on Forms of Medical Practice and the Malpractice Committee into a single unit called the Medical Practice Committee.

I wish to thank Drs. Bailey, Doolittle, Fujii, Ivar Larsen and Edmund Ing for their cooperation throughout the year.

## LEGISLATIVE COMMITTEE

**B. Allen Richardson, M.D.**

The Legislative Committee consisting of Drs. Alvin Majoska, Richard T. Kainuma, H. L. Arnold, Jr., John W. Devereux, Samuel L. Yee, H. Q. Pang, Richard C. Durant and Richard K. C. Lee, met weekly during the 1953 Legislative session. The Legislative Committee of the Honolulu County Medical Society and the Territorial Medical Association met jointly.

The most important piece of medical legislation was House Bill 692. This was the bill allowing free choice of physician in Workmen's Compensation cases. The bill passed both houses but died by pocket veto.

Since the end of the 1953 Legislative session, the Committee has had no occasion to meet.

I wish to thank all the members of the Legislative Committee of the Honolulu County Medical Society for their active participation on this Committee.

## MALPRACTICE LIABILITY INSURANCE COMMITTEE

**C. E. Fronk, M.D.**

On August 17, 1953, the following letter was written:

Your Malpractice Committee has held several meetings with Mr. E. A. Kudlich, President of the Oahu Insurance Agency, and also with the representative of the Home Insurance Company. This matter was so involved and there were so many technicalities to be discussed that our committee recommended that the entire matter be brought before the Board of Governors for their information and action. We recommended that at this meeting Mr. Kudlich and the Home Insurance Company representative be present so that each in turn may present their proposals.

A meeting was held a few days later at which Mr. Kudlich and a representative of the Home Insurance Company were present and each presented their problems. The consensus of this meeting was that no recommendation be made to the Society as a whole favoring one company over the other.

During the present year, there has been a slight decrease in the number of malpractice suits and the amounts involved are somewhat lower. On October 17, 1953, the following letter of recommendation was made by our committee:

Your Malpractice Committee recommends that the Medical Society appoint a committee of physicians to act as advisors to the insurance company and to the physician concerned before any action is taken involving any malpractice suit that may be brought against any member of the Society.

I talked only yesterday with a representative of the Home Insurance Company who handles the majority of the malpractice suits. They are firmly of the opinion that such a committee would be of very great benefit and we again make this recommendation.

## MEDICAL COMMITTEE OF THE HAWAII MEDICAL SERVICE ASSOCIATION (HMSA)

**R. T. West, M.D.**

During the past year, the Medical Committee of the HMSA has had meetings once a month, every other one being a dinner meeting. To these have been invited other doctors of this Society, and employer and Labor representatives.

The HMSA is in a sound financial position. During the past calendar year, $2,088,983.94 was received from dues and of this $1,090,779.00 was paid out to the doctors and $640,616.00 to the hospitals. In other words, benefit payments amounted to 83.2 cents out of every dollar paid in premiums. For the past consecutive five years, your Plan has returned over 80 cents in benefits out of every dues dollar.

All of you have received a notice concerning the increase in medical, surgical and hospital benefits which went into effect as of January 1, 1954. For all basic plans, waiting periods for treatment of medical illnesses were waived (except for pre-existing conditions). The limitations on surgery and hospitalization for surgery on chronic or pre-existing conditions were eliminated; hospitalization benefits on chronic medical illnesses were increased; and allowance for hospitalization away from the Territory of Hawaii was increased to $16.00 per day. For the Comprehensive Plan, more hospital benefits were added and waiting periods for maternity benefits reduced to 9 months of membership in a family plan.

Functional, mental or emotional disorders were added to the list of exclusions.

As of March 1, 1954, HMSA has a reserve fund of $469,857.00 which has been wisely invested in securities bearing about 3% interest. This amount represents a net worth per member of $6.39. This does not include the $70,470.90 (as of March 1, 1954) which has accumulated from the 9% withholding from bills for doctors' services. This latter fund, which is to be used only for deficits in experimental plans where actuarial data is not obtainable, has not been touched to date. In June 1954 the withholding will drop from 10% back to the basic 1%.

During the past year, HMSA enrolled 21,109 new members, and had a net gain of 8,829 members. This brings the total membership up to 71,933 as of December 31, 1953.

Your Medical Committee has been very much aware of the impact that the labor unions have had not only on the future of HMSA, but also on our practice of medicine. We feel that the union leaders are insidiously taking over the control of the practice of medicine and maneuvering to eliminate in a round-about-way the present free choice of physician. We feel that only by proper leadership and by a united stand for what we feel to be right, will the practice of medicine as we know it now survive. Time is running out.

The Wolverton Bills are an attempt to get federal government aid into the voluntary health program. If such bills are passed, we feel that we will be pushed further down the steps which lead to the socialization of medical care for the people of the U.S.A. The Board of Directors of the HMSA feel that a well-run and financially-sound prepaid medical plan which is properly supported by the doctors and hospitals has no need for Federal assistance or control.

Your Medical Committee does not want to appear pessimistic, but we feel that it is high time that our Medical Society make a comprehensive investigation of the trends of medical practice and formulate some sort of policy behind which we can and will all stand together. In only this way will the practice of medicine as we now know it and our prepaid medical plan, the HMSA, survive.

**PROGRAM COMMITTEE**

**Toru Nishigaya, M.D.**

Your Committee was responsible for nine scientific programs through the year (June-Sept.-Oct.-Nov.-Dec.-Jan.-Feb.-March).

In June, February and March we presented such outstanding mainland authorities as Dr. R. Schindler, Dr. E. Kost Shelton and Dr. H. O. McPheeters.

In November we held our meeting at the Territorial Hospital at Kaneohe. A very enjoyable and enlightening evening was had through the courtesy of the professional staff there and through Wyeth, Inc. (donors of the food).

Our annual fun and social meeting was held in December at the Oahu Country Club. October and November were devoted to local talents, with a commentary on Hawaiian fish by Mr. Spencer Tinker.

In January the staff of the Tripler Army Hospital was invited to prepare the program for the meeting. This occasion not only availed the membership of an excellent medical program, but also helped to cement our bonds of friendship with the Armed Forces medical personnel.

In addition we instituted a new process whereby a representative of different pharmaceutical houses was asked to appear on the program when feasible. This has been a tremendous boost to these men.

Your Program Committee works under a decided handicap in attempting to present a program pleasing to all. Our meeting date is conducive to too much absenteeism because of competing athletic and other social events. The Society is faced with the problem of small attendance at its monthly meetings, and consequently, only a small segment of the membership is actually conducting the business of the organization.

We therefore recommend that:

1. The regular meetings of the Honolulu County Medical Society be changed to some other night than Fridays. Meetings to begin promptly at 8:00 P.M.
2. The practice of permitting pharmaceutical representatives to appear on the program be continued.
3. The practice of utilizing renowned mainland speakers be continued.
4. We have at least one fun and social meeting during the fiscal year.
5. We utilize "local" talent on their merits, and also in conjunction with mainland speakers.
6. Papers on non-medical subjects but of scientific interest be presented. Many community problems and interesting subjects could be presented and discussed.
7. The program include periodic reports of the Executive Secretary in regard to the Bureau as well as other public relations and related medical subjects. Also the committee to ferret out pertinent information from the various committees as well as HMSA and have them reported to the membership.
8. Lastly, utilize on biennial basis, staffs of the Board of Health, Territorial Hospital, Tripler Hospital, Leahi Home, Hale Mohalu and other medical agencies.

**POSTGRADUATE COMMITTEE**

**Shoyei Yamauchi, M.D.**

The Society has depended for the past few years upon the generosity of the Cancer Society and other health agencies for our annual postgraduate lectures. We felt that this policy should be discontinued as there has been an abundance of cancer and surgery with little emphasis on general medicine. However, the Cancer Society came to our rescue and agreed to invite Dr. Jerome W. Conn, an eminent authority in the field of endocrinology. Dr. Conn is with the Division of Endocrinology and Metabolism at the University of Michigan at Ann Arbor. He will present eight lectures to the Medical Society, beginning May 3, and will give the featured address at the Hawaii Medical Association's annual meeting. We are fortunate in having Dr. Conn and feel certain that you will find his talks stimulating.

In May of 1955, the Cancer Society will present Dr. Lauren V. Ackerman, a well known pathologist, now associated with the Department of Surgery at the Barnes Hospital in St. Louis. It is our understanding that Dr. Ackerman is an excellent speaker and conducts his lectures in a most unusual manner.

We would like to recommend that in the future, committees select their speakers one year in advance, as this policy of long-range planning would permit a greater choice of lecturers.

I wish to thank Drs. Cushnie, Gilbert, Kainuma, Peyton, L. Q. Pang and Spencer for their splendid cooperation throughout the year.

**PUBLIC SERVICE COMMITTEE**

**C. C. McCorriston, M.D.**

The major arbeit of your Public Service Committee this year was the selection of the Executive Secretary of the Honolulu County Medical Society. After many weeks of deliberation and many interviews, your Society picked Mr. Richard M. Kennedy. It is our hope that more

members of the Society will find that the services of the Bureau of Medical Economics, also headed by Mr. Kennedy are worthwhile. Public relationwise, we believe that collections handled through our Bureau of Medical Economics leave a much better taste with the public than accounts collected by some high-pressure method.

The members of your committee, as members of the Territorial Public Service Committee, met with the representatives of the press, radio and television on March 2, 1954, at the third annual Public Relations Committee–Press-Radio Dinner. This was a big success. The initial attitudes of suspicion prevalent during the first meeting were noticeable by their absence. We had taken care of a good deal of their major former previous complaint of "whom shall we call?", by referring them to our Executive Secretary. I believe that each of us can see more clearly, as we get better acquainted, each other's viewpoints, and the pleasant exchange of give-and-take at this meeting was on an increasingly friendly basis, winding up with one member of the press suggesting, somewhat jocularly,* that the press stand the cost of the next dinner.

I want particularly to thank the other members of the committee who served with me, Dr. Sylvia Haven, Dr. Robert Katsuki, Dr. Homer Izumi and Dr. David Pang, all of whom worked very hard this year.

## WOMAN'S AUXILIARY

**Mrs. C. M. Burgess**

We have just completed our fifth year as an auxiliary. Our program is governed by our advisory board of doctors and the requests they and the President of the County Medical Society make. Mrs. Wiig, program chairman, and her committee have presented programs which have followed the outline of the National Auxiliary as nearly as possible and yet fit into our community needs.

There have been ten meetings of the Board this year, one a joint meeting with the Executive Board of the Woman's Auxiliary to the Territorial Medical Association. The general membership has met five times.

The June meeting was a luncheon at Tripler Officers' Club preceded by a tour of Tripler Hospital.

The September meeting consisted of a panel representing several of the local major health agencies explaining their function. We entertained the women of the Auxiliary to the Dental Association at this meeting.

The December meeting was a very informative picture presented by the Hawaii Cancer Society on "Self-Examination of the Breast" with Mrs. Inez Cayaban as commentator.

March 5 we tried our first evening meeting in the Lounge of Mabel Smyth Building, having our husbands as our guests for refreshments after their meeting in the Auditorium. From all comments this meeting was a success and was well attended.

Members of the auxiliary have sat in on doctor's committees to plan the social activities of the Territorial Meeting in May, the post A.M.A. tour in June, and the Pan-Pacific Surgical Convention in October.

We have been quite successful in promoting the sale and distribution of "Today's Health," which is published by the A.M.A. and should appear in every doctor's waiting room.

We have contributed a sum of money to the American Medical Education Foundation which is trying to raise two million dollars to subsidize medical schools.

We have under consideration the purchase of a piano for the Lounge of Mabel Smyth Building and have decided to go ahead with these plans.

March 16 our annual meeting was held to complete the year's business. The following officers were elected:

| | |
|---|---|
| Mrs. Laurence M. Wiig | *President* |
| Mrs. P. Howard Liljestrand | *President Elect* |
| Mrs. Peter Washko | *Vice President* |
| Mrs. William H. Stevens | *Recording Secretary* |
| Mrs. Donald Depp | *Corresponding Secretary* |
| Mrs. Albert H. Ishii | *Treasurer* |
| Mrs. Theodore Tomita | *Historian* |
| Mrs. Homer Benson, Mrs. Joseph Lam | *Members at Large* |

Our Executive Board feels the aims and purpose of the Auxiliary have been carried out as fully as possible. We wish to express our appreciation to Dr. Ito, our Advisory Board and the other committees with whom we have worked for their cooperation in making this year a successful one for the Auxiliary.

## HONOLULU COUNTY MEDICAL LIBRARY BOARD OF GOVERNORS

**W. Harold Civin, M.D.**

During the past year the members of the Board were: Dr. Civin, President; Drs. Berk, Ishii, Richardson, James Wong, Wayne Wong, Kawasaki, Patterson, Yamauchi, Felix, Lester Yee; Dr. Fronk as representative from the Advisory Committee and Dr. O. D. Pinkerton as Chairman of the Library Committee.

The Library Endowment Fund was increased by $3,877.75, less expenditures of $244.81, leaving a total fund now of $85,268.21. Many members have still not given to the Endowment Fund, and the Board has decided to circularize them, asking their contributions toward this endeavor to make the Library self-supporting.

Contributions from hospitals which utilize the Library have been forthcoming in 1954. Amounts were increased by Queen's and Kuakini Hospitals. We wish to acknowledge, with thanks, the following contributions: $600.00 from Queen's, $150.00 from St. Francis, $100.00 from Kuakini and $100.00 from Children's Hospital. We wish also to gratefully acknowledge contributions for the purchase of books and journals from the following organizations: The Public Health Committee of the Chamber of Commerce, $750.00; National Foundation for Infantile Paralysis, $250.00; Oahu Tuberculosis Association, $100.00. These funds are being used for purchases in the particular fields in which the donors are interested.

Our auditors recommended last year that our records show the value invested in our book and journal collection. We now have more than 17,000 volumes in the collection. It has been assessed at a value of approximately a quarter of a million dollars.

The Board has been concerned with the rental proposal made by the building's Board of Management this year. After a consultation with representatives from all interested parties, the Board decided that the Library should remain free of rental charges. Documents relating to the original intent of the benefactors of the Library were found, substantiating this contention. Dr. Patterson prepared a resolution to this effect so that it will be a matter of future record.

The membership should know that the Library Board has been exploring the possibility of securing additional space. Stacks have been placed in the Reading Room and alcove, and the facilities of our present quarters are very nearly exhausted. Dr. Walker, of Leahi Hospital, has generously offered us stack space, which will help relieve some of the pressure this next year. However, the

* Editor's note: It is our understanding that this suggestion was made in all seriousness.

Board must plan for constant library growth in the future, and our thinking is along these lines.

The Board has decided against asking our specialty societies and groups for monetary contributions for books and journals, since this is doubly taxing our doctor members who are already contributing through Medical Society dues.

We were saddened by the death of Dr. Halford, who was Chairman of the Endowment Fund Advisory Committee. Dr. Louis Gaspar was appointed to replace him, and the Advisory Committee is now composed of Drs. Fronk, Min Hin Li and Gaspar. In Dr. Halford's memory, a generous contribution to the Endowment Fund was made by the doctors of the Medical Group, and other contributions from outsiders were also placed in the Endowment Fund, since this is the project he was most devoted to.

**LIBRARY COMMITTEE**

**Ogden D. Pinkerton, M.D.**

Our statistical report for the past year shows the steady growth of the Library, and our collection now totals over 17,700 volumes—well over 1,000 volumes more than we had in 1952. (This is approximately 160,000 single issues.) New books added totalled 279, most of them publishers' gifts, review copies to the HAWAII MEDICAL JOURNAL. Any others have been purchased from special contributions such as those from the Cancer Society, National Foundation for Infantile Paralysis, Tuberculosis Association, Public Health Committee of the Chamber of Commerce, Hawaii Chapter of the American College of Surgeons, etc. Four hundred eighty-seven journals are being received currently.

Following a long established policy, our funds are spent mainly on maintaining journal subscriptions. All sources of securing gift subscriptions are constantly explored, in order to economize. In this regard we wish to acknowledge gifts of regular subscriptions from the following: Doctors Berk, Kobayashi, Giles; Arnold, Sr.; Arnold, Jr.; Richardson, Tilden, Patterson, Spencer, Herter, French, Fennel, Cloward Pleadwell, Larsen, Pinkerton, West, Hosoi, Fronk, Florine, Ho, Hunter and Sia. Various doctors from the Medical Group and the Straub Clinic have been kind enough to turn over their subscriptions to the AMA specialty journals. We are also grateful to various pharmaceutical companies for gifts of their publications, and to each of the following who give us journals regularly, either by gift or subscription: the U. S. Public Health Service, Mrs. C. F. Weeber, the Bureau of Mental Hygiene, The Tuberculosis Association and the National Foundation for Infantile Paralysis. Moreover, we are indebted to the HAWAII MEDICAL JOURNAL for 165 current exchanges, not only with other state journals, but for many valuable and interesting foreign publications that are currently being received.

Our registered borrowers now include 346 doctors (including interns and associate members), 730 nurses (R.N.'s and students), and 50 guest or staff members of contributing organizations.

Our staff of one full-time and one part-time librarian, and a part-time clerical helper, has handled over 3,925 telephone requests for reference and research. The Committee approved putting in an extension telephone line to the stack and work room to save some of the footwork and time. Requests for help in the Library totaled 1,173. Requests for research from our doctor members have been on a steady increase, and it is becoming a heavy burden for our small staff to handle this in addition to carrying on regular library routines.

This year over 20,200 books were used in the Library (an increase of over 3,000), and 10,256 books and journals were used, making an increase in circulation of approximately 2,000 over last year. This clearly shows the growing demand for the use of library resources. Student use of the library has shown such an increase, and placed such a demand on our small staff, that the Committee has had to ask professors at the University of Hawaii and Punahou School to limit student requests to items absolutely necessary and unavailable elsewhere.

The Board of Medical Examiners authorized an additional grant of $1,350.00 for books and stacks to be added to their collection, which has been widely used. We are most grateful for their continuing support.

We wish to acknowledge with thanks all gifts of books and journals from our members. These have all contributed to completing our collection and added to its value as an investment and its usefulness in research reference. We wish to remind our members that the Library can use any journals they wish to discard.

# Hawaii Medical Association

## SPRING MEETING

**March 29, 1954 at 8 P.M.**

**Mabel Smyth Building**

Dr. Edwin K. Chung-Hoon, presided. There were 108 present, including 14 visiting doctors and their wives from the New Orleans Graduate Medical Assembly. The following program was presented:

*Obstetrical and Gynecological Problems,* by E. H. COUNTISS, M.D.

*Diagnosis and Management of Common Types of Clinical Asphyxia,* by D. BATTAGLIA, M.D.

*Coins and Medals Relating to Medicine,* by W. E. FOUNTAIN, M.D.

*Ancient Hawaiian Medicine,* by N. P. LARSEN, M.D.

*The Mimicry of Leprosy,* by E. K. CHUNG-HOON, M.D.

*Movie on Ventricular Excision for Leiomyosarcoma,* by PAUL GEBAUER, M.D.

Refreshments were served on the lanai.

SAMUEL L. YEE, M.D.
*Secretary*

# Notes and News

## THOMAS LACY TAYLOR, D.O., M.D.
## 1879-1954

Dr. Thomas Lacy Taylor was born on August 23, 1879, in Trenton, Tennessee, and died in Honolulu on March 14, 1954.

He received the degree of D.O. from the American School of Osteopathy in 1901, and the degree of M.D. from the Indiana University School of Medicine in 1908. He served on the staff of the Indiana State School for Feebleminded Youths and the State Institution for Feeble-minded at Frankfort, Kentucky.

On March 20, 1926, he arrived in Honolulu to become superintendent of the Waimano Home, where he was one of the pioneers in the institutional care of the feeble-minded. His work there was particularly impressive in his personal relations with the unfortunate inmates. It was heartwarming to see the children following him about as if he were their parent, and actually calling him "father." It was obvious that they loved him and he reciprocated their affection.

Because of failing health, he was transferred in 1941 to less strenuous work at the Territorial Hospital at Kaneohe, where the undersigned was closely associated with him for several years. He accepted his new role graciously and was happy in continuing to be of service. He took a keen interest in his work and conscientiously did his best in each instance. Dr. Taylor was retired from the Territorial Hospital in 1950 by reason of age and health.

He was always pleasant, friendly, soft-spoken, and mannerly, with a keen sense of humor. He was clean and temperate in his thoughts and in his habits. He was a member of the First Methodist Church of Honolulu and of its Official Board.

Dr. Taylor was a member of Honolulu Lodge No. 409, Free and Accepted Masons; Honolulu Scottish Rite Bodies; Aloha Temple, Ancient Arabic Order Nobles of Mystic Shrine; and Leahi Chapter No. 2, Order of the Eastern Star.

He was a member of the Honolulu County Medical Society, Hawaii Territorial Medical Association, American Medical Association, and the American Psychiatric Association. He was an honorary member of the American Association on Mental Deficiency.

The family, the community, and the medical fraternity have sustained a real loss in the death of Dr. Taylor. It would be a much better world if there were more good, honorable, and upright gentlemen of his caliber.

R. D. KEPNER, M.D.

## FREDERICK LINCOLN MORONG, M.D.
## 1877-1954

Frederick Lincoln Morong, M.D., died at the Queen's Hospital, February 22, 1954 from a reticulum cell sarcoma.

Dr. Morong was born June 5, 1877, in San Francisco. He received his elementary education in that city and after three years at the University of Washington, he entered the University of California Medical School, from which he was graduated in 1901. He interned in the old German Hospital in San Francisco, now called the Franklin Hospital, from 1901 to 1902. After three years of private practice in San Francisco, he joined the U. S. Public Health Service in Honolulu, but resigned in 1906 to become the plantation physician at Kahuku, where he practiced for four years. In 1910, he entered private practice in Honolulu and continued in active private practice until 1953, when he retired because of ill health. He was an active member of the Honolulu County Medical Society for thirty-five years. On October 8, 1948, the Society honored him with life membership.

For twenty-five years, Dr. Morong was a Major in the National Guard on the Commanding Officer's Staff, from which he was retired in 1942.

Dr. Morong was a kindly, soft-spoken, considerate gentleman, who was intensely interested in the practice of medicine and in whom his patients had great confidence. He was greatly beloved by both members of his profession and his many friends.

HENRY C. GOTSHALK, M.D.

## PERSONALS

**Dr. Joseph Strode** attended the meeting of the American Surgical Association in Cleveland, Ohio. Following this, he and Mrs. Strode plan to visit Europe.

**Dr. Samuel D. Allison** was elected president of the local Johns Hopkins Alumni Association.

**Dr. William John Holmes** was appointed by Governor King as a member of the Hawaii Foreign Aide Trainee Program Committee.

**Dr. James Kuninobu,** veteran Boy Scout leader, was awarded the Silver Beaver Award for distinguished service to boyhood by the Boy Scouts of America.

**Dr. and Mrs. Kyuro Okazaki** attended the American College of Physicians Annual Session in Chicago. While on the mainland, Dr. Okazaki is planning to do graduate work at the Graduate School of Cook County Hospital and at the University of Pennsylvania.

**Dr. and Mrs. Leslie Vasconcellos** left in April for a medical trip which will take them around the world. On their itinerary are the meetings of the Congress of the International Society of Surgery in Paris, the European Section of the International College of Surgeons in Turin, Italy, and the International Congress of Catholic Doctors in Dublin, Ireland.

**Dr. Satoru Nishijima** was elected Chief, **Dr. Toru Ni-**

**shigaya,** Vice-Chief, and **Dr. John Devereux,** Secretary, of the Medical Staff of the Kapiolani Maternity and Gynecological Hospital.

**Dr. Masamichi Narita** announces the removal of his office to 3454 Waialae Avenue.

At the request of the Governor of Guam, **Dr. John H. Peyton** and **Dr. Richard S. Dodge** conducted a poliomyelitis diagnostic and care program on the Island of Guam.

**Dr. Khai Fai Li,** prominent Chinese physician, died at the age of 79. Dr. Li is survived by nine children of whom several are physicians. With his late wife, **Dr. Tai Heong Kong Li,** he pioneered in many fields of medicine in the Territory of Hawaii. In addition to his surgical activities, Dr. Li was the founder of the Constitutional Association of Hawaii, the Mun Lun School, and the New China Daily News.

Three Honolulu physicians addressed Parent-Teacher groups on subjects pertaining to their specialties: **Dr. Don C. Marshall** spoke on "The Physical Growth of a Child" before the PTA Christian League of Our Redeemer Lutheran Church, **Dr. William H. Stevens** discussed "Emotional Development of Children" for parents at Punahou School, and **Dr. William John Holmes** spoke to parents at the Diamond Head School (the former Territorial School for the Deaf and Blind) on "Modern Trends in the Education of Blind Children."

**Dr. and Mrs. Jerome Peacock** announce the birth of their first child, a daughter, born March 24, 1954. Dr. Peacock, the son of a kamaaina family, is in the pathology department of Queen's Hospital.

**Dr. and Mrs. John Felix** announce the birth of their fifth child and first daughter, Barbara Claire, born on April 3, 1954.

Congratulations to **Dr. Fred K. Lam,** who was one of two former graduates of St. Louis University School of Medicine to be presented with the key of Alpha Omega Alpha, a national honorary medical scholastic fraternity.

**Dr. Dean M. Walker** was married to Miss Gladys K. Williams on March 19, 1954 in the Pilgrim Chapel of the Central Union Church.

**Dr. Robert G. Johnston** was elected president of the Pacific Club for the year 1954.

**Dr. Akira Kutsunai** and **Dr. Arthur J. Okinaka** of Honolulu received their M.D. degrees at the University of Chicago's spring commencement.

**Dr. Marquis Stevens** left Honolulu early in March to take postgraduate studies at the University of Michigan Medical School. He will return to his practice in June. Mrs. Stevens has been visiting her family in Europe.

Papers presented by Honolulu doctors at the annual meeting of the Pacific Coast Oto-Ophthalmological Society held here April 25 to 29 included *Changing Concepts of Ocular Leprosy* by **W. J. Holmes,** *Ocular Findings in Disseminated Lupus Erythematosus* by **Thomas Cowan,** *Removing the Backache from Cataract Surgery* by **Philip Corboy,** *Clinical Demonstrations in Hansen's Disease* by **E. K. Chung-Hoon,** *Genetic Analysis of the Hard of Hearing* by **Tadao Hata,** *Hansen's Disease of the Eye, Ear, Nose and Throat* by **F. J. Pinkerton** and *Surgical Correction of Laryngeal Stenoses Due to Leprosy* by **John Frazer.** Guest of honor at this meeting was **Dr. A. Ray Irvine, Sr.** from Los Angeles.

The Straub Clinic announces the association of **Dr. Thomas P. Frissell** in the Department of Ophthalmology. Dr. Frissell is a native of Honolulu and graduated from Iolani School. He received his M.D. from the University of California and interned at the San Francisco City and County Hospital. He then took a special three year residency at the Highland Alameda County Hospital. Dr. Frissell is married and has two sons.

There were 130 doctors and wives registered at the Kauikeolani Children's Hospital for the Post Spring Session of the Academy of Pediatrics held in Honolulu April 13 following the Academy's Los Angeles meeting. All of the scientific papers were presented by local doctors, as follows: *Children's Feet in Hawaii* by **Donald Marshall,** *Rupture of the Stomach in Newborns* by **Masato Hasegawa,** a case of *Cooley's Anemia* presented by **Elizabeth Jones** and discussed by **L. T. Chun,** a case of *Letterer-Siwe's Disease* presented and discussed by **George Ewing,** *Leprosy* by **Harry Arnold, Jr.** and a round table discussion of *Rheumatic Fever in Hawaii* led by **Teruo Yoshina, Angie Connor** and **Morton Berk.** The visiting doctors were all made honorary members of the Honolulu Pediatrics Society. The group also enjoyed a tour of Mrs. Lester Marks' garden, luncheons at the Oahu Country Club and at Children's Hospital, and cocktails and a luau at the Waialae Country Club.

**Dr. and Mrs. L. Q. Pang** greeted their fifth child, Malcolm, on March 1.

On December 27, 1953, **Miss Dorothea Lopez** become the bride of **Dr. Herbert Pang.**

**Dr. Thomas S. Min** and **Dr. Casimir A. Domzalski** are now Fellows of the American College of Physicians.

**Dr. Harry L. Arnold, Jr.** was recently made a member of the Hawaii Chapter of Sigma Xi.

## Maui

Congratulations are due **Dr. Robert A. Rose** who passed the second and final part of the American Board of Surgery held in January of this year in Los Angeles. Dr. Rose is connected with the Pioneer Mill Company in Lahaina.

**Dr. Maxwell Boyd** has opened his office in Wailuku for the practice of medicine and surgery.

**Dr. Raymond Otsuka** has opened his office in Wailuku for the practice of dermatology. He is a graduate of Rush Medical and was a staff member at Cook County Hospital. Dr. Otsuka is a diplomate of the American Board of Roentgenology and has partially completed his requirements for the Board in Dermatology.

## NEWS

### "Nine Doctors and God"

"Nine Doctors and God," by the late Dr. Francis J. Halford, has been accepted for publication by the University of Hawaii Press. The book is expected to be published some time this fall, if possible, in time for The Pan-Pacific Surgical Conference early in October.

Dr. Halford spent a great deal of time gathering data on the early missionary doctors in the Islands, and has produced a book that should be of exceptional interest both in the Islands and on the Mainland, says Thomas Nickerson, head of the University Press.

Most of the material is taken from the diaries and letters of the early doctors and their wives. The book gives a graphic picture of the primitive conditions under which these early physicians lived and practiced their professions.

Four of the nine missionary doctors remained in the Islands until death, and special stress is laid on their work. They are Dr. Gerrit P. Judd of Honolulu, Dr.

Charles Hinckley Wetmore of Hilo, Dr. Dwight Baldwin of Maui, and Dr. James William Smith of Kauai.

The Press is searching for two photographs needed in illustrating the book. One is a photo of Dr. Abraham Blatchley, who was stationed at Kailua, Hawaii, and at Waiakea from 1823 to 1826. The other is a photo of Dr. Wetmore's home in Hilo, in which he had his office and his drug dispensary.

Dr. Halford tried without success to find these photos. The Press is continuing the search and will welcome any information on the subject.

### Want to Fly?

Private Flying Club interested in new members, age 28 up. License not necessary. Call C. Y. Dyke at the Bishop National Bank or E. A. Eckert, Kailua 264811.

### The American Congress of Physical Medicine and Rehabilitation

The 32nd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 6-11, 1954 inclusive, at the Hotel Statler, Washington, D. C.

Scientific and clinical sessions will be given September 7, 8, 9, 10 and 11. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

### Physician Wanted

The Kamehameha Schools need either a part-time or a full-time doctor to handle their infirmary and health problems, beginning with the opening of school approximately August 15 of this year.

They prefer a man who can take this position on a full-time basis. It is realized that a position of this type will not be as remunerative as a private practice, but there is a wonderful challenge and opportunity in this work.

The president of The Kamehameha Schools, Colonel Harold W. Kent, would be pleased to discuss this position with any interested individual.

### Situation Wanted

Graduate of Class A medical school desires position in Hawaii upon completion of Air Force tour of duty. Have had training and experience in general practice with emphasis on OB-GYN during service enlistment. Qualifications, and references furnished upon request. Robert Olson, M.D., 3320th Med Gp, Amarillo AFB, Texas.



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The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

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# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAM, *Executive Secretary*, Honolulu

BULLETIN COMMITTEE

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## ECONOMIC SECURITY WORKSHOP

In 1950 the House of Delegates authorized the Nurses' Association, Territory of Hawaii, Inc., Board of Directors to take all the necessary steps in the "establishment and forwarding" of an economic security program.

The basic step in the establishment of such a program is the setting up of functions, standards, and qualifications, and recommended minimum employment conditions for each specialty area. The nurses in each section are responsible for the setting up of their own. Not much has been done in this program because of lack of knowledge as to how to proceed.

April 2, 3, and 4 a workshop was held in Honolulu for section members who will be serving on Committees on Functions, Standards, and Qualifications and on Committees on Minimum Employment Conditions. As indicated in the workshop program sent to the general membership, outstanding leaders in this field were used as lecturers. The workshop, through lectures, discussion groups, and resource people gave these committee members some of the principles and procedures involved in the establishment of the economic security program.

The members of the workshop felt that there was a definite need for such a program because of the following benefits:

Increased job satisfaction which keeps nurses in nursing.

Better recruitment into the nursing field.

Improved working conditions for nurses which lead to improved nursing practice.

What are the steps each section should take in setting up Functions, Standards, and Qualifications?

Functions, Standards, and Qualifications of each section should:

1. Establish classifications in each group section. Example: General Duty, Head Nurse, Staff Nurse.
2. Write summary of duties, job description.
3. Give examples of duties.
4. Define minimum qualifications necessary to carry out these duties (knowledge, skills).
5. Set up a few tools that can be used as guides by the committees in the establishment of functions, standards, and qualifications, and minimum standards of employment.
6. Facts are needed, it is recognized—How to get these facts.
   a. Decide within each section what its members want to know (prepare unit questionnaire).
7. Chairmen of each Functions, Standards, and Qualifications Committee meet as a coordinating group and pool section findings by preparing a coordinated questionnaire. Send this questionnaire to NATH Board for suggestions and recommendations.
8. Select people to obtain these facts from nurses. Steps:
   a. Use associate members. To be trained for interview work by NATH office.
   b. Oahu District members to be used here and sent to other islands, or
   c. Bring association members from other islands, train and send back.
9. Explanatory letter to hospital administrator. Att.: Director of Nurses, explaining project and asking their cooperation in permitting interviews of random chosen personnel in their area.
   a. Select 10-20% each type classification.
10. Interview and collect material.

11. Evaluation of material in NATH Evaluation Committee.
12. Set up Functions, Standards, and Qualifications. Then "price" your product—
"Minimum conditions of employment." This should all be done on Territorial level, but each section should decide what role district sections would take.

Following is a summary of group discussions related to the setting up of minimum conditions of employment.

1. Executive Committee of sections should appoint immediately a committee on minimum conditions of employment.
2. Section committees must decide what kind of information they want regarding existing conditions. (See Exhibit III in Manual.)
3. Submit this information to a NATH coordinating committee (representatives of all sections plus resource people [personnel administrators]).
4. Sections to send out individually or cooperatively one questionnaire (with parts for each section concerned).
5. Section committees compile results.
6. Consider and interpret results in terms of similar information from mainland nurses, other professions essentially female (local and mainland), and the cost of living index.
7. Consider and interpret in terms of Functions, Standards, and Qualifications.
8. Develop recommended minimum conditions of employment.
9. Submit to section membership for consideration and approval or revision.
10. After acceptance by section membership, sent to NATH Board of Directors for acceptance.
11. These standards then become the accepted minimum conditions of employment for the section.
12. Section recommends to NATH Board methods of implementing these recommendations; such as, mimeographing and sending to all section members, to all employers, etc.

*Recommendations:*

1. That NATH Board be informed of the need for coordination of section activities and provide means of providing this coordination probably through the Economic Security Committee.
2. That one group collect the pertinent data needed by all sections; i.e., comparison of cost of living index; comparison with comparable professions, as social workers, teachers, etc.
3. NATH Board make similar workshops available on other islands if the district associations feel the need.
4. That nurses be encouraged to form local units to implement the economic security program.
5. That NATH Economic Security Committee become active in assuming responsibility for continuing education to nurses on the economic security program. Public Relations is essential. This may be in conjunction with Public Information Committee.

## THE ECONOMIC SECURITY PROGRAM AND WHAT IT CAN DO FOR YOU*

From a book called "Nurses, Patients and Pocketbooks," published in 1928, I quote the following: "The fact that nursing is an idealistic profession does not render it immune to economic laws. If nursing is to retain its high idealism, it must make sure that its members are free from undue economic pressure." As you can see, our problem today is not a new one.

During the 1940's it became obvious that nurses could no longer remain isolated from the forces that were affecting society as a whole. So members of the American Nurses' Association, through their House of Delegates, in 1946, adopted the economic security program. This program aims to help all nurses attain a standard of living and a measure of security in line with the vital professional service nurses render, and the educational preparation required of them. And you do render vital professional services. The nursing profession presupposes qualities out of the ordinary: a solid training—that is, technical knowledge thoroughly acquired and constantly kept up to date—and a nimbleness of mind capable of continuously gleaning new ideas, applying new methods, and using new instruments and medicines.

Since the beginning of the ANA economic security program, delegates at every biennial convention have added new policies to strengthen the program and support its growth. It is interesting to note some of the major policy-making decisions.

In 1946 the House of Delegates approved policies which said that the state nurses associations should be the exclusive voice for nurses in matters affecting their employment. At the same meeting the House called for elimination of practices that bar nurses of minority racial groups from employment, and also called for the development of collective bargaining technics by state nurses associations.

In 1948, the House of Delegates called attention to the fact that the establishment of "joint programs for economic security for nurses" by state nurses associations, in conjunction with state hospital associations, is inconsistent with the principles of the economic security program adopted by the ANA. State associations were advised not to draw up contracts with employers of nurses without proper authorization from nurse employees affected. The House of Delegates recommended that properly organized section committees formulate the employment standards for their groups, and at that same biennial authorized the establishment of criteria for evaluating state economic security programs. These criteria continue to be one of the most useful tools for SNA's in measuring the progress of their programs. The delegates also urged careful and continuous consideration of legislative activities which would improve the status and privileges of nurses under national labor laws. The Economic Security Unit follows the proposals for changes in Federal laws which directly affect the economic interests of nurses. For example, this year, during the first session of the 83d Congress, testimony on amending the Taft-Hartley Act and revision of the Income Tax Laws was prepared by the ANA Economic Security Unit and presented in Washington.

It was at the biennial in 1950 that the ANA House of Delegates adopted the "no-strike" policy. This policy has two parts—both equally important. The first part

* *Excerpts from an address given at the 47th Annual Meeting, by Adel Heruitz, R.N., Associate Executive Secretary of the American Nurses Association—Kentucky State Nurses Association Bulletin.*

states that professional nurses voluntarily relinquish the right to strike, and then goes on to say that because nurses voluntarily relinquish this right, they hold that employers have a moral obligation to deal justly with nurses through their authorized representatives. The 1950 House of Delegates also established the policy that the nurse should maintain a neutral position when there are labor disputes at her place of employment. With an increase in the number of nonprofessional workers employed by hospitals and agencies, this policy has become even more significant.

In 1952, the House of Delegates called for action to put the 40-hour week for employed nurses into effect throughout the country. They further urged that registered professional nurses be compensated for any work which they do beyond the basic 40-hour week, at the standard rate of time-and-one-half. The number of nurses working a 40-hour week is increasing and it is generally accepted as a desirable goal. However, the 40-hour week as the basis for pay, with time-and-one-half for overtime, is not generally understood and accepted by nurses and employers. Nursing needs and staffing shortages may necessitate a 44-hour week, but the four additional hours worked should be compensated for at the rate of time-and-one-half.

The change in structure brought increased importance to sections, and with the increasing importance of sections has come the increasing awareness of the relationship of the economic security program to section development. You work through your state section to establish your specific goals and through your section activities the benefits of the program are brought back to you as an individual.

The establishment of subunits within the state sections provides machinery for you to be grouped in appropriate units for consideration of the economic security program. In order to safeguard the economic security program against any possible criticism from members or the public who might say that one category of nurses dominated another category—the subunit formation came into being. The subunit is an integral part of a state section and consists of section members employed in similar positions on the same level who can be grouped for the purpose of setting employment standards. For example, the public health section is made up of staff nurses, supervisors, consultants, etc. Their economic interests and employment conditions differ. So the state public health section might have several subunits—one for all public health staff nurses of a state section, one for consultants, etc. Nurses, through their sections and section subunits, are establishing statewide employment standards and seeking their adoption by employers.

The methods of implementing the economic security program vary for each category of nurses. For example, you who are public health nurses employed by official agencies may be represented before the proper authority for the purpose of securing revision of regulations or new legislation covering your employment conditions. You who are private duty nurses may put your state employment standards into effect through the nurses' official registries, while you who are general duty nurses may have your desired improvements set forth clearly in a written agreement with your employer.

Much progress has been noted since the program got under way. Marked improvements in employment conditions have been made in the states that have full-fledged programs. The technic of collective bargaining is receiving wider acceptance by the profession as a democratic method for improving employment conditions. In areas where collective bargaining has become the established procedure for determining nurses' employment conditions, salaries have been increased as much as 59% since 1946. Higher salaries, shorter hours, and improved working conditions are important, but they do not constitute the whole picture. Even more important is the respect for nurses' rights and prerogatives as citizens of a democracy.

The Economic Security Program is based on the principle that you have the democratic right to a voice in reaching decisions which affect your welfare. A patient with chest surgery has pain when he takes a deep breath, but with the best intentions, sympathy, and skill, we can't breathe for him—only he can do it. And so, in a way, the same thing applies to the Economic Security Program. The ANA staff will make available to you all the know-how that has been accumulated over the years, but in the final analysis—you must want an Economic Security Program—you must feel the rightness of it—you must act to get it under way.

## RADIO AND TV COMMERCIALS MUST CONSIDER THE PROFESSIONAL ETHICS OF NURSING

Sponsorship of a radio or TV program featuring nurses or even a fictional member of the nursing profession presents the problem of how to utilize the good will of large groups of people who will respond positively to appeals but who will be offended if anybody's professional ethics are violated.

The ethical code of nurses, insofar as it relates to radio and TV advertising, is summarized in the January 1954 issue of *ANA Guide Lines*, a monthly publication of the American Nurses' Association which goes to leading nurses throughout the country. Here the ANA reaffirms that—

1. A nurse's name can't be used in the endorsement of a product.
2. A registered nurse in uniform, even though unidentified, can't appear in an ad or commercial if this would imply professional endorsement.
3. Since nurses understand that only a physician may prescribe treatments and medication, special care must be taken in commercials advertising pharmaceutical or therapeutic products.

What, then, can a sponsor do if he wants to use a program which features nursing or a nurse?

The pitch can be taken from public service advertising. Here the sponsor is on safe ground—and it is entirely possible that his appeal will be *more* effective than an overt or an implied endorsement.

The weakness of endorsement of a commercial product by members of any profession lies in the fact that it calls attention to the product's competitive position and plants a doubt.

Some of the pitfalls of endorsement advertising have been discovered by the tobacco companies very recently.

Writers of commercials are being challenged these days to come up with ideas appealing and different, with copy *more* likely to build good will for their products and customers who will buy.

Commercials which have a relationship, however indirect, to the nursing profession can be tied in by suggestions with the high purposes and human interest appeal of nursing.

What does the show itself accomplish? It gives

vicarious experiences — identifies the listener or viewer with the forces which triumph over evil—brings laughter, tears, the happy ending. A product, too, can shine brightly in the mind through its part in bringing to the audience the pleasure and vital satisfactions of dramatic entertainment. Everything is make-believe, and yet . . .

The sponsor's product can influence an audience through actively promoting the forces which bring pleasure, comfort, healing, and understanding to the listener or viewer.

How about a salute to the nursing profession? To its code?

How about letting the star speak for the advertiser's sponsorship of good causes?

Whereas the endorsement appeal may lose its savor, the public service field for ideas in advertising can be used to go straight to the heart, and it can be safe for the sponsor if his commercials add one ingredient to the specifications he gives his copywriters. This is *understanding positive values of the service he takes on as part of his promotion.*

## ACTION OF YOUR BOARD OF DIRECTORS

March 12, 1954

Board members present: 6
Board members absent: 5
Committee chairmen present: 4

*Approved* minutes of Board meeting November 13, 1953 and treasurer's report.

*Took* action in relation to correspondence:

1. Renewed membership ($10) in Oahu Health Council.
2. Endorsement of Red Cross program.
3. Approved attendance of Legislative Committee Chairman, Mrs. Myrtle Schattenburg, at the ANA Conference on Legislation to be held June 28, 29, 30 at Morraine-on-the-Lake, Illinois. ANA will pay transportation.

*Ratified* two mail votes:

1. Resolution that "any two of the following officers, namely, the president, the treasurer, or the secretary, be and hereby are authorized to execute on behalf of the corporation all necessary documents to carry out all the corporation's activities including all documents connected with the Margaret Jones Memorial Fund."
2. That an economic security workshop be set up.

*Heard* reports of committees:

*Program*—Mrs. Alice Scott
Annual meeting to be held around last of September or first of October for three days. More time to be planned for section meetings.

*Economic Security*—Harriet Kuwamoto
The Economic Security Committee, made up of NATH section chairmen, met preceding the Board meeting and elected Mrs. Gladys Leong as chairman. Sister Mary Albert, Chairman of the Workshop Committee, reported on progress of plans.

INTER-ISLAND BULLETIN—Mrs. Toshiko Ono

*Library*—Mrs. Cynthia Wolfe (for Chairman, Mrs. Angela Stempel)

*Took* action on committee recommendations:

1. That NATH make available the sum of $500 for the economic security workshop. This to cover all expenses including expenses of those asked to attend from the other islands.
2. Referred to Finance Committee request from the Medical Library that NATH increase annual contribution of $300 to $400.

*Heard* report from Mrs. Elaine Johnson, NATH Representative on Board of Management, Mabel Smyth Building.

*Reviewed* and approved information to be sent to districts regarding prorated membership quota.

*Discussed* delegates to ANA Biennial:
Each section is entitled to one, except general duty which is entitled to two.
Board may appoint three delegates-at-large.
These may vote for officers by proxy if unable to attend.
The following have been appointed (with no expense to NATH):
General Duty—Mrs. Leila Miyamoto (vacationing)
Institutional Nursing Service Administrators—Mrs. Patience Martelon (attending National Tuberculosis Association meeting in Atlantic City following the Biennial)
Educational Administrators, Consultants and Teachers—Miss Mary Neal (now on the mainland because of illness in her family)
Industrial—Mrs. Agnes Kick (vacationing)
Special Groups—Miss Leona Adam (to attend Board for Licensing meeting preceding the Biennial)
At-Large—Mrs. Helen Gage (business on mainland)
The President was instructed to appoint other delegates as indicated.

*Discussed* section budgets. The matter was referred to Finance Committee.

*Wrote* off the books of the Margaret Jones Memorial Fund a $200 loan made to a nurse now deceased and leaving no estate.

*Approved* revision of rules for Institutional Nursing Service Administrators Section.

*Empowered* President to appoint someone to represent NATH on special committee to consider revision of nurse practice act.

*Empowered* President to appoint a committee to study and formulate a plan to determine the desires of the county associations in health legislation and to transmit these desires to the Legislative Committee.

*Heard* reports:
Mrs. McCall—ANA Advisory Council held in New York in January.
Miss Leona Adam — Human Relations Workshop sponsored by Oahu Health Council and Mental Hygiene Society in January.

*Next* meeting: June 18, 1954

* * *

The Executive Committee (Sub-NATH) met March 19, 1954 to discuss some problems in relation to the Economic Security Program. Lt. Col. Brady, First Vice President, presided. Miss Myrna Campbell represented the other islands.

## NEWS

### Nurses' Association, County of Kauai

Nurses from Kauai who were married recently are Josephine Cortezan to Raymond Duvauchelle on February 19, Hilda Nemoto to Allen Michioka on February 19, Esther Nakame to Motomi Shigeta on March 6, and Juanita Sabala to Elifeo Umipeg on February 25.

The engagement of Rosario Dela Cruz to Lawrence Carvalho was anounced on Christmas Eve. Miss Dela

Cruz, a 1951 graduate of St. Francis Hospital School of Nursing, is employed at Wilcox Memorial Hospital.

Mrs. Opal Catlin and Mrs. Greeba Dale, both of Waimea Hospital, have left Kauai for the mainland. Miss Helen Eguchi of Waimea replaces Mrs. Catlin as surgical supervisor.

The Nurses' Association, County of Kauai, has been consulted by the students of the local high schools regarding available nursing scholarships and information on practical nursing. At present there are eight active scholarship students. Miss Elizabeth Middleton is the local interviewer for practical nurse aspirants.

One of the new members of the Association is Jan Baker of Columbus Hospital, Seattle, Washington.

Mrs. Miyoko Masunaga of Mahelona Hospital left for Japan on March 28 on the President Cleveland. She will be away for three months. Miss Ida Oganeku, Wilcox Hospital, accompanied by her mother, left for Japan by plane on April 1.

## Nurses' Association, County of Hawaii

November 25, 1953 and December 29, 1953 were Lurline Days in Hilo. Four nurses from the County of Hawaii were asked to assist on these days at the first aid stations, which were set up by the Hawaii Visitors Bureau and the Red Cross of Hilo. The Boy and Girl Scouts also assisted on these days. There were two stations: one at the Hawaiian Village, located in the Keaukaha Area in Hilo; the other at the pier. At each of these stations, two nurses were responsible for all emergencies. After 1 p.m. the nurses exchanged stations in order to give everyone an opportunity to go on board the ship to look over the hospital set up.

The nurses here are asked to assist wherever and whenever possible by the different organizations. Assisting on these occasions is usually on voluntary basis.

Much excitement can be anticipated by the nurses. A change from the routine can be fun.

**Personals:**

Mr. and Mrs. Masanori Hongo announced the birth of a daughter last year. Mrs. Hongo, the former Helen Kitagawa, was on leave of absence and is now back on duty in surgery as assistant head nurse at Hilo Memorial Hospital. She is a graduate of Queen's Hospital School of Nursing and has had postgraduate work in surgery at Johns Hopkins Hospital, Baltimore, Maryland.

Mrs. Emma Lau from the Department of Health is now on leave of absence.

Miss Hanako Higa has joined the nursing staff in Hilo. She was in the Army and served three years in Texas, Korea, and Japan. Miss Higa is a graduate of Kuakini Hospital School of Nursing.

The Nurses' Association, County of Hawaii, welcomed the following new nurses to the Association: Misses Dolores Christensen, Marian Ida Lind, and Mrs. Lucille N. Cushnie from Kohala Hospital; Misses Chiyoko Kano, Hanako Higa, and Mrs. Melinda Lopez from Hilo Memorial Hospital; Miss Mona McMichael from Pahala Hospital; Miss Lorraine Ishikawa from the Department of Health.

## Maui District Nurses' Association

The Maui District Nurses' Association had their annual dinner meeting at the Wailuku Hotel Gardens in January.

The new officers for 1954 were presented by Miss Elizabeth Morishige, President. Elected were the following:

| | |
|---|---|
| *Vice President:* | Ruth Schindler |
| *Recording Secretary:* | Margaret Watanabe |
| *Corresponding Secretary:* | Joyce Ishibashi |
| *Directors:* | Lorraine Arakaki |
| | Helen Goshi |
| | Marilyn Estill |
| | Ann Gillin |
| | Charlotte Ringrose |
| | Judith Magarifuji |
| | Okuni Tanner |

Miss Elizabeth Morishige, President, and Marian Meseroll, Treasurer, will serve for another year.

Lovely orchid corsages from D. Frank A. St. Sure were presented to all officers and board members.

Ten new members were accepted into our District Nurses' Association. They are: Setsuyo Ushiro, Theresa Muller, Hisako Ogata, Cecelia Enomoto, Cynthia Cheu, Ruth Mizoguchi, Darrell Gwynn, Katherine Seeger, Jessie Tackleberry, and Florence Muroki.

Five new nurses have joined the staff of the Kula Sanatorium. They are: Cecelia Enomoto and Ruth Mizoguchi who are graduates of mainland schools of nursing; Cynthia Cheu from St. Francis Hospital School of Nursing; Darrel Gwynn and Katherine Seeger who are from Canada.

Misses Barbara Kline and Joanne Lockhart, from San Jose, California, have joined the Puunene Hospital staff.

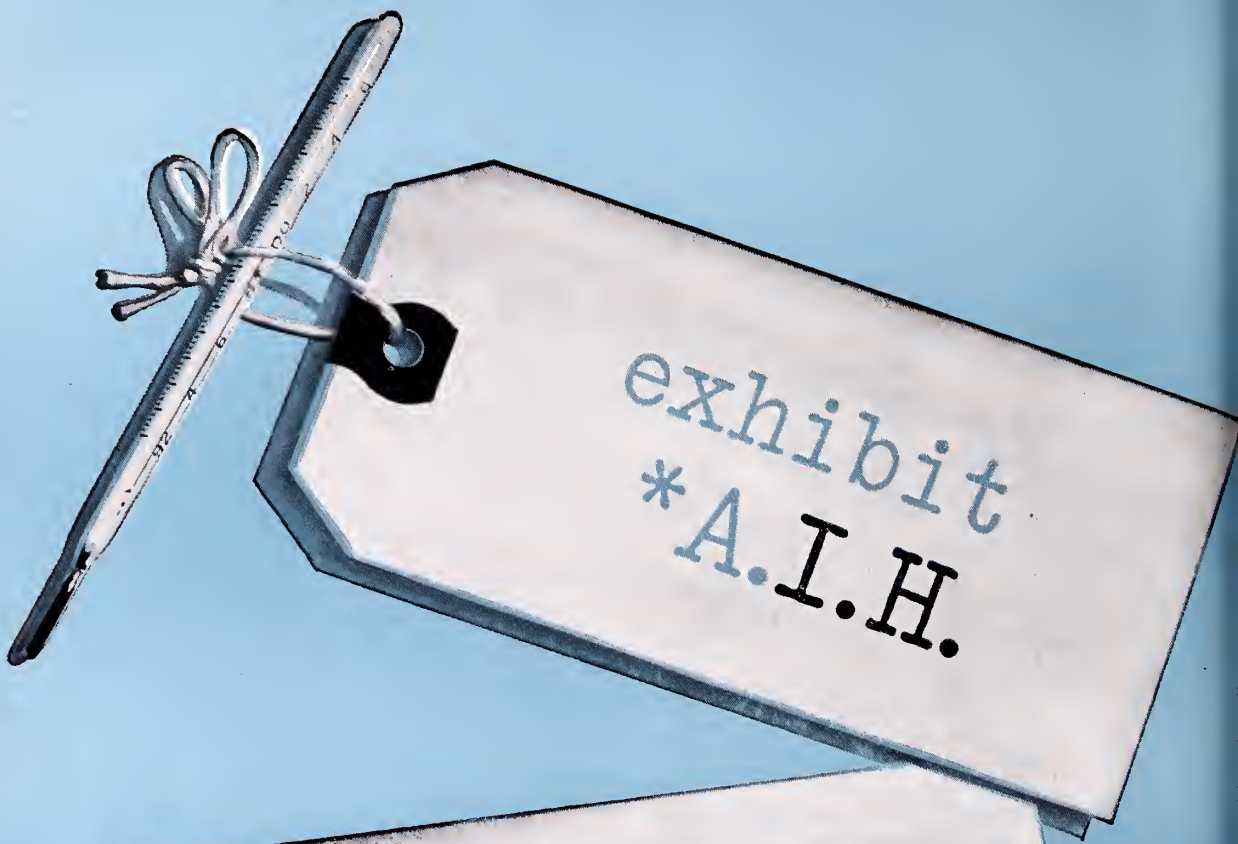
Misses Ikue Kaita and Ann Arisumi have returned to their home town and are on the staff of the Pioneer Hospital in Lahaina. Both are recent graduates of The Queen's Hospital.

Miss Marilyn Estill of the Central Maui Memorial Hospital staff became Mrs. Walter Waikiki on Valentine's Day, February 14.

Miss Beatrice Fujimoto, on the nursing staff of Kula Sanatorium, became Mrs. Lawrence Sakai on February 20.

Miss Katsuko Takiguchi of the Central Maui Memorial Hospital nursing staff left for the University of Washington to study for a degree in nursing education.

Mrs. Corrine Jackson Freeman of Puunene died at Puunene Hospital, where she formerly served as head nurse, after having been hospitalized for three months. Mrs. Freeman was born March 4, 1886, at Chiles Valley, Napa Valley, California. She graduated from Trinity Hospital School of Nursing in San Francisco, and came to the Islands in 1923 to join the staff at Hawaiian Commercial & Sugar Co., Ltd.'s Puunene Hospital. She later was promoted to head nurse. She served at Puunene for 15 years and retired in 1938 to marry William I. Freeman, who is presently agricultural engineer superintendent at the HC&S Co.




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"Symptoms, including fever, largely cleared up within 24 to 48 hours"*

# BASIC among broad-spectrum antibiotics

*true broad-spectrum action*
*against pneumococci, streptococci,*
*staphylococci and other*
*gram-positive and*
*gram-negative pathogens*

*unexcelled tolerance*

*outstanding stability*

*high blood levels quickly*
*reached and maintained*

*may often be effective*
*where resistance or sensitivity*
*precludes other forms of*
*antibiotic therapy*

**racyn** *hydrochloride*

brand of **tetracycline** hydrochloride

Tetracyn Tablets *(sugar coated)*

250 mg., 100 mg., 50 mg.

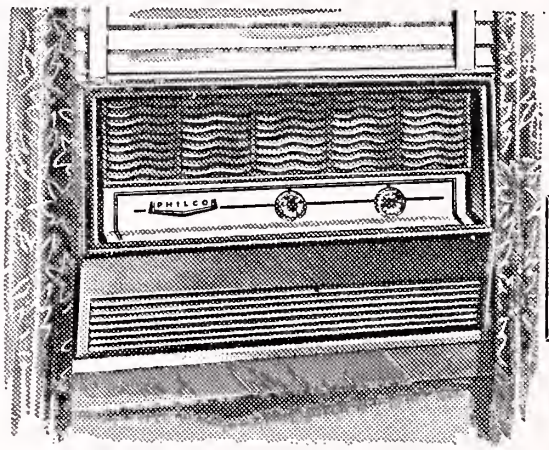
**English, A. R., et al.: Antibiotics Annual (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.*

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# PHILCO *Air Conditioner*




MODEL 101KS

- MOUNTS FLUSH WITH WINDOW SILLS
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*for 17 consecutive years the LEADER in*
**AIR CONDITIONER SALES and DEPENDABILITY**

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***For Full Details***

Easy APPLIANCE CO.

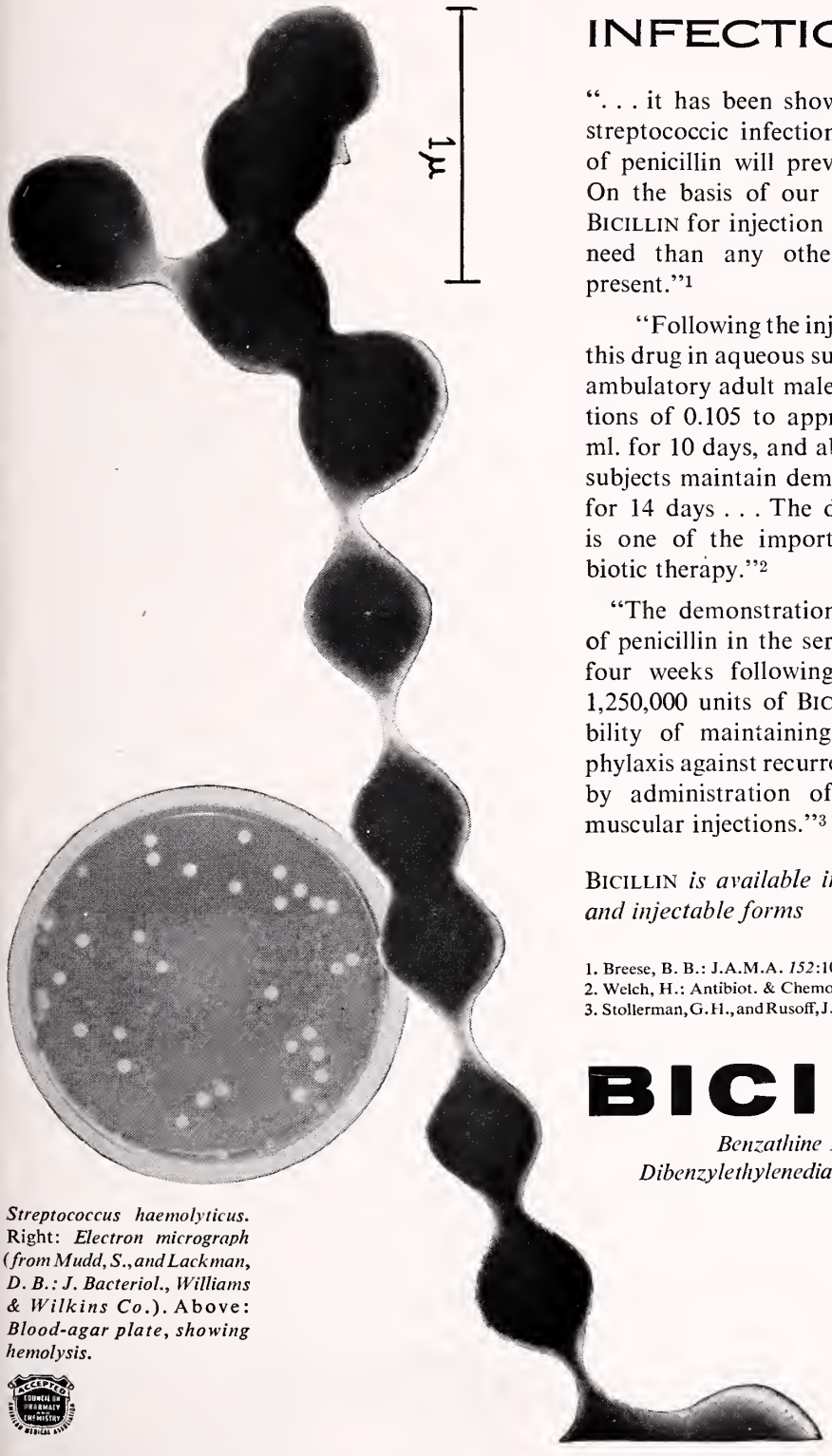
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*Price is long forgotten though the satisfaction of using fine printing remains. Fine printing costs little more than printing that might be termed "good enough." Many professional men use with pride fine printing from the*

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**of the**
**HONOLULU STAR-BULLETIN**

We print the
Hawaii Medical Journal

# SUSTAINED PENICILLIN LEVELS IN STREPTOCOCCAL INFECTIONS




*Streptococcus haemolyticus.* Right: *Electron micrograph (from Mudd, S., and Lackman, D. B.: J. Bacteriol., Williams & Wilkins Co.).* Above: *Blood-agar plate, showing hemolysis.*

"... it has been shown that the treatment of streptococcic infections by adequate amounts of penicillin will prevent rheumatic fever ... On the basis of our experience, we feel that BICILLIN for injection more nearly supplies the need than any other product available at present."[1]

"Following the injection of 600,000 units of this drug in aqueous suspension, 100 per cent of ambulatory adult males show blood concentrations of 0.105 to approximately 0.03 unit per ml. for 10 days, and about 50 per cent of these subjects maintain demonstrable concentrations for 14 days ... The development of BICILLIN is one of the important milestones in antibiotic therapy."[2]

"The demonstration of detectable amounts of penicillin in the serum of most patients for four weeks following the administration of 1,250,000 units of BICILLIN suggests the feasibility of maintaining continuous drug prophylaxis against recurrences [of rheumatic fever] by administration of single monthly intramuscular injections."[3]

BICILLIN *is available in oral suspension, tablet, and injectable forms*

1. Breese, B. B.: J.A.M.A. *152*:10 (May 2) 1953
2. Welch, H.: Antibiot. & Chemo. *3*:347 (April) 1953
3. Stollerman, G. H., and Rusoff, J. H.: J.A.M.A. *150*:1571 (Dec. 20) 1952

# BICILLIN®

*Benzathine Penicillin G*
*Dibenzylethylenediamine Dipenicillin G*

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Modern lighting depends on adequate wiring. Then, at the flip of a switch, you can put new beauty, comfort and safety into any part of your home. And lighting is the biggest bargain in sight.

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**Stairs, inside or outside, should be bright without shadows. Place light over each landing, at top or bottom—not over stairs where the bulbs will be difficult to replace.**

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Your home-owned electric utility
Bringing you better living — electrically



# NEW

## *to pediatric practice*

Established in leading hospital nurseries as a superior antiseptic detergent for personnel who handle infants and for routine bathing of newborn, pHisoHex is now available for home use. pHisoHex combines pHisoderm with powerfully bactericidal hexachlorophene. It is indicated as an exclusive, routine hand wash for mothers and nurses; instead of soap or oil for bathing babies, and for removing excreta; for cleansing minor wounds; for infectious dermatoses.

pHisoHex is unusually rapid as a detergent and maintains skin virtually free of bacteria *for hours*. It is safe for the tenderest skin because it is nonirritating, hypoallergenic and contains no alkali, potash or fatty acids.

*Exclusive and daily use* can keep the skin virtually sterile in most instances.

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# 3 GLASSES OF FRESH MILK A DAY

## can do this much for your patients!

**1** HELPS THEM TO SLEEP BETTER. A glass of fresh milk just before bedtime relaxes, helps them to sleep sooner and sleep more soundly. Milk relaxes the blood vessels, aids circulation and eases the hunger that sometimes keeps a person awake. A warm drink of fresh milk at bedtime, is even more relaxing.

**2** EASES NERVOUS TENSION. Tests of a number of nervous children and adults prove that drinking three glasses of milk every day helps reduce fatigue and strain. Milk is so good, so refreshing—and, unlike other beverages, it contains no drugs that may increase nervousness.

**3** ENDS CALCIUM STARVATION. More Americans suffer from calcium deficiency than from any other dietary lack. We all need calcium all our lives for teeth, bones, and proper body functioning. Milk is the only practical source of calcium. Three or four glasses every day provide the daily calcium requirement for a normal adult.

**4** BUILDS STRENGTH, NOT FAT. Milk is the best source of digestible low-cost protein, Vitamin A, riboflavin, and calcium, which the body needs every day. Yet milk calories are relatively *low* in fat. High protein reducing diets built around milk are comfortable and safe.

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DOCTOR—your assistance is needed in reminding Hawaii's people of the importance of milk in their diet. Tell your patients about these 5 milk facts. Their increased fresh milk consumption today means a healthier Hawaii tomorrow!

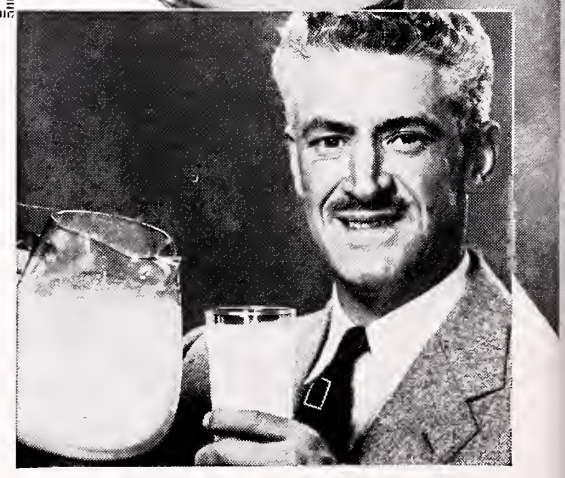



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**FRESH RICH MILK and DAIRY PRODUCTS**

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**Important:** "Drinking at least three glasses of milk every day is one of your best and cheapest health habits. Milk's value to you is far greater than its cost." Herrell DeGraff, Professor of Food Economics, Cornell University.

DOCTOR, WHEN YOUR PATIENTS ASK...

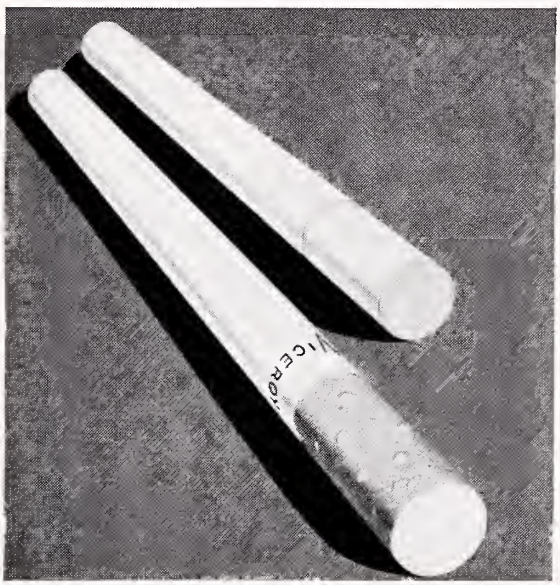


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...REMEMBER THAT NEW VICEROY GIVES SMOKERS

## DOUBLE THE FILTERING ACTION!





**1.** NEW AMAZING FILTER OF ESTRON MATERIAL

This new-type filter, of non-mineral, cellulose-acetate, Estron material, exclusive with Viceroy Cigarettes, represents the latest development in 20 years of Brown & Williamson filter research. Each filter contains 20,000 tiny filter elements that give efficient filtering action; yet smoke is drawn through easily, and flavor is not affected.

**2.** PLUS KING-SIZE LENGTH

The smoke is also filtered through Viceroy's extra length of rich, costly tobaccos. Thus Viceroy actually gives smokers *double the filtering action* . . . to double the pleasure and contentment of *tobacco at its best!*



ONLY A PENNY OR TWO MORE THAN CIGARETTES WITHOUT FILTERS

*New King-Size*

*Filter Tip* VICEROY

OUTSELLS ALL OTHER FILTER TIP CIGARETTES COMBINED



# WHEN SYMPTOMS ARE DISTRESSING BUT DISGUISED . . .

"It is strange," Malleson says, "how little clinical recognition" has been given to the "negative behavior" or "endogenous misery" of the woman with endocrine imbalance. Largely accountable for this, of course, is the patient's own reluctance to discuss these symptoms with her physician until she actually suffers from some of the more obvious menopausal symptoms such as hot flushes. Even then she may become so accustomed to her change in feeling she can't remember what it's like to feel well.[1]

Changes in the mood pattern are just a few of the many distressing symptoms of declining ovarian function which are so often disguised because they do not always coincide with cessation of menstruation, and at times will occur long before, and even years after. Other good examples are insomnia, headache, easy fatigability, arthralgia — and understandably so, when one considers that the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism."[2]

"Premarin" is a preparation of choice for the replacement of body estrogen. "Premarin" presents a *complete* equine estrogen-complex and all the components of this complex are meticulously preserved in their natural form. This largely explains why "Premarin" not only produces prompt symptomatic relief but also imparts an important "plus" — the distinctive "*sense of well-being*" that patients find so highly gratifying. These benefits of "Premarin" have made it a natural estrogen widely prescribed by physicians . . . and often preferred by patients.

"PREMARIN"®

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

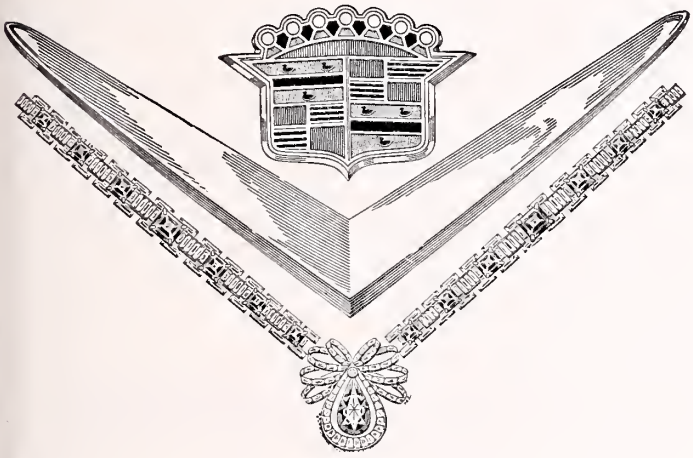
**has no odor**
**. . . imparts no odor**

*Estrogenic Substances (water-soluble), also known as conjugated estrogens (equine), available in both tablet and liquid form*

1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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# Cadillac

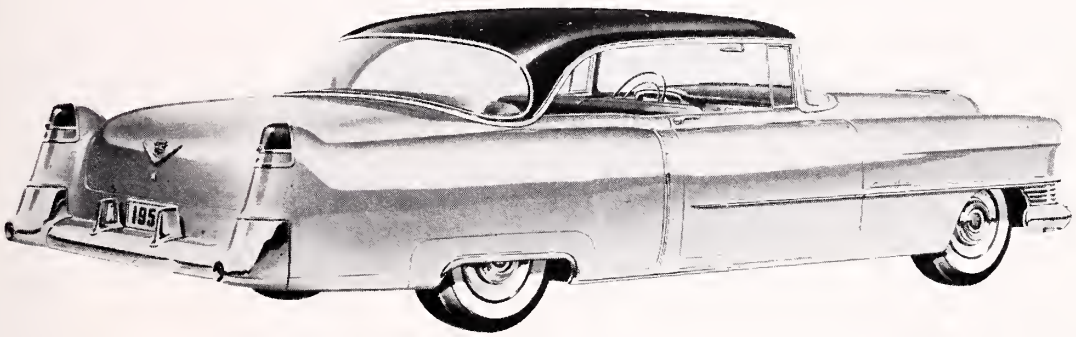


Today, Cadillac has become an international symbol of all that is good and desirable in the automotive world—the special favorite of the most discriminating motorists to be found anywhere.

The 1954 Cadillac is the greatest Cadillac of them all—more beautiful, more distinguished—and with the finest performance of all time.

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# Thank You...

*The S. J. Tutag Company proudly announces*
COUNCIL ACCEPTANCE OF TASTY, STABLE,

**BUFFONAMIDE**
Brand of
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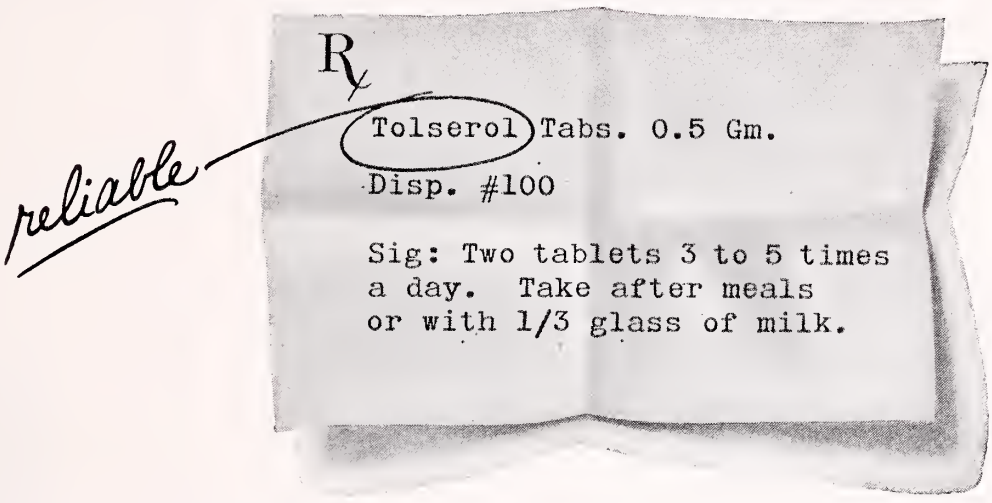
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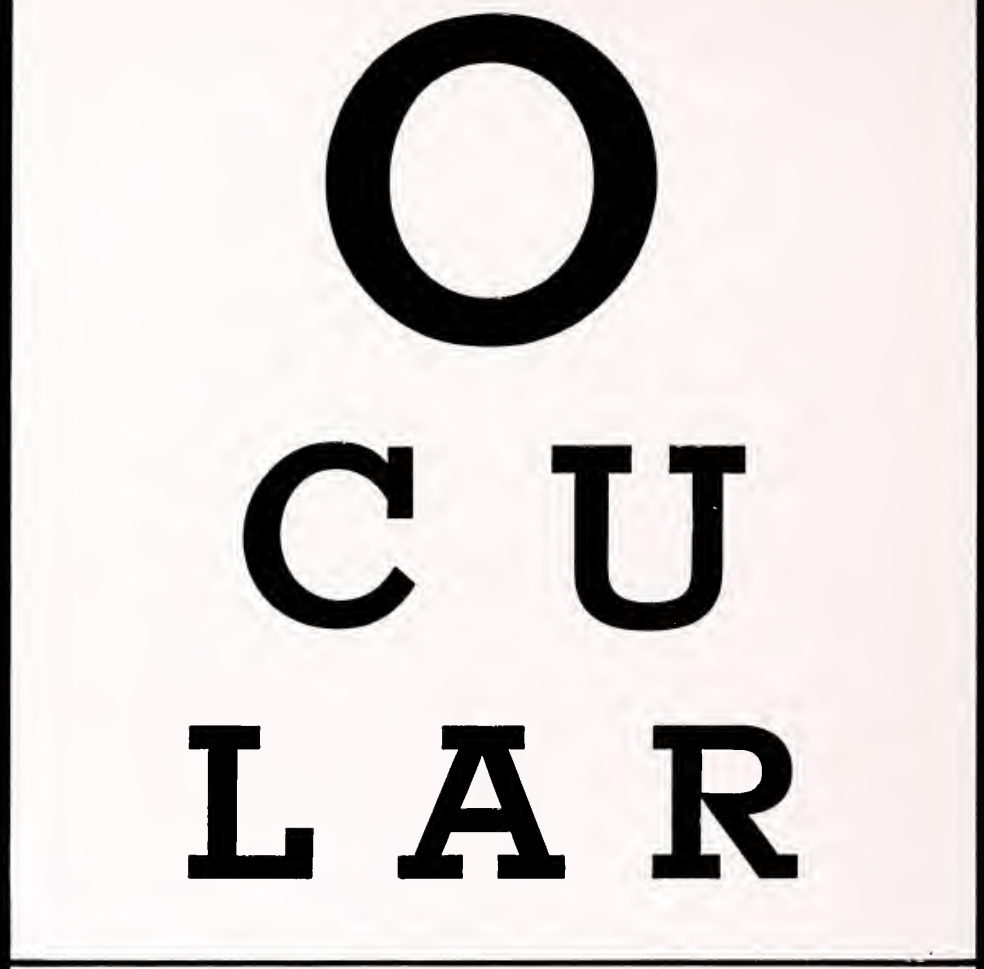
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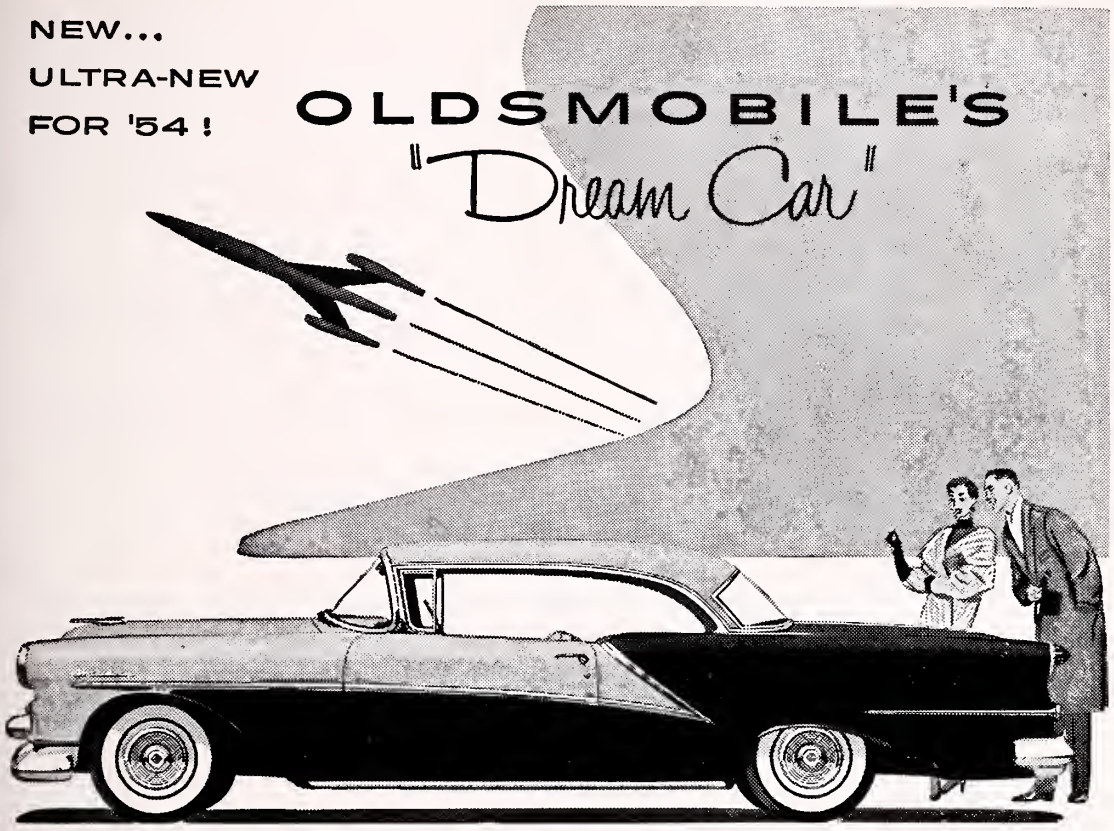

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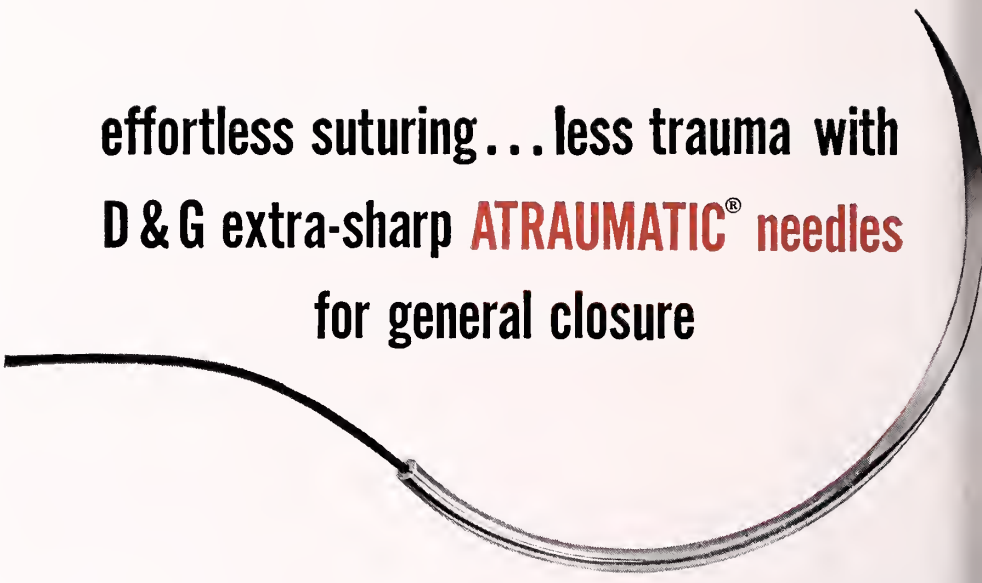
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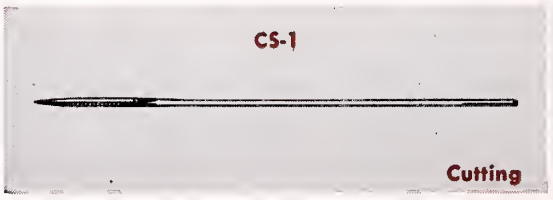
Did you know that these 9 temper-tested, hand-finished D & G Atraumatic needles are combined with a *variety* of suture materials? More and more surgeons use them for general closure and ob.-gyn. surgery because there is a fresh, sharp needle for each situation, no tug to clear the needle, less injury to tissues. Important, too—no threading, no dropped needles.

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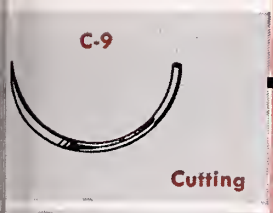
## general closure sutures

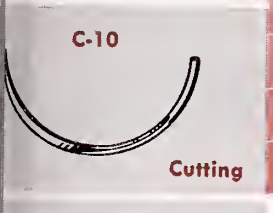
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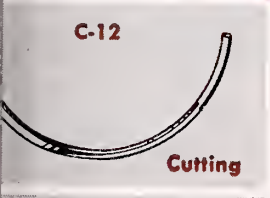
| No. | Type | Length | Needle | Sizes |
|---|---|---|---|---|
| 1509 | A, Plain | 27" | T-9 | 00 to 1 |
| 1546 | C, Med. Chromic | 27" | T-9 | 000 to 2 |
| 1508 | A, Plain | 27" | T-12 | 00 to 1 |
| 1548 | C, Med. Chromic | 27" | T-12 | 000 to 2 |
| 1561 | C, Med. Chromic | 27" | T-18 | 000 to 1 |
| 1563 | C, Med. Chromic | 27" | T-19 | 00 to 1 |
| 1547 | C, Med. Chromic | 27" | C-9 | 000 to 2 |
| 687 | C, Med. Chromic | 27" | C-10 | 000 to 2 |
| 689 | D, Extra Chromic | 27" | C-10 | 00 |
| 685 | D, Extra Chromic | 27" | C-12 | 0 to 2 |
| 693 | C, Med. Chromic | 27" | R-1 | 00 to 1 |
| 691 | D, Extra Chromic | 27" | R-1 | 00, 0 |

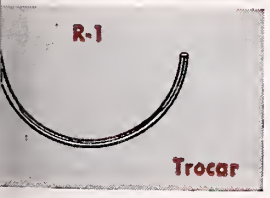
**ANACAP® SILK:**

| No. | Material | Length | Needle | Sizes |
|---|---|---|---|---|
| 1378 | Black Braided Silk | 30" | C-9 | 000 to 1 |
| 1379 | Black Braided Silk | 30" | T-9 | 000 to 1 |
| 1380 | Black Braided Silk | 30" | CS-1 | 000, 00, 0 |
| 1397 | Black Braided Silk | 30" | T-12 | 000 to 2 |



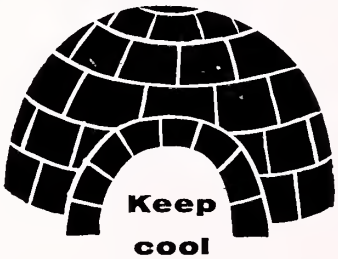

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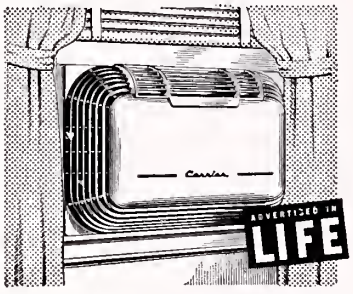
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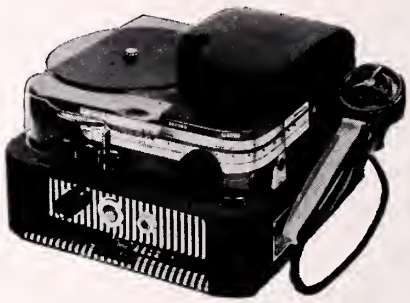
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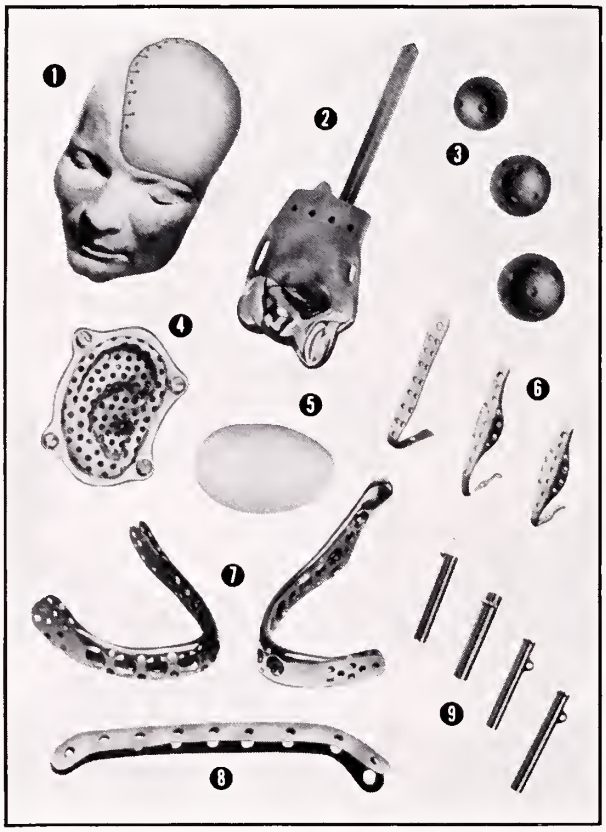
1. Thorn, G. W., *et al.*, *New England J. Med.* **248**:632, April 9, 1953.

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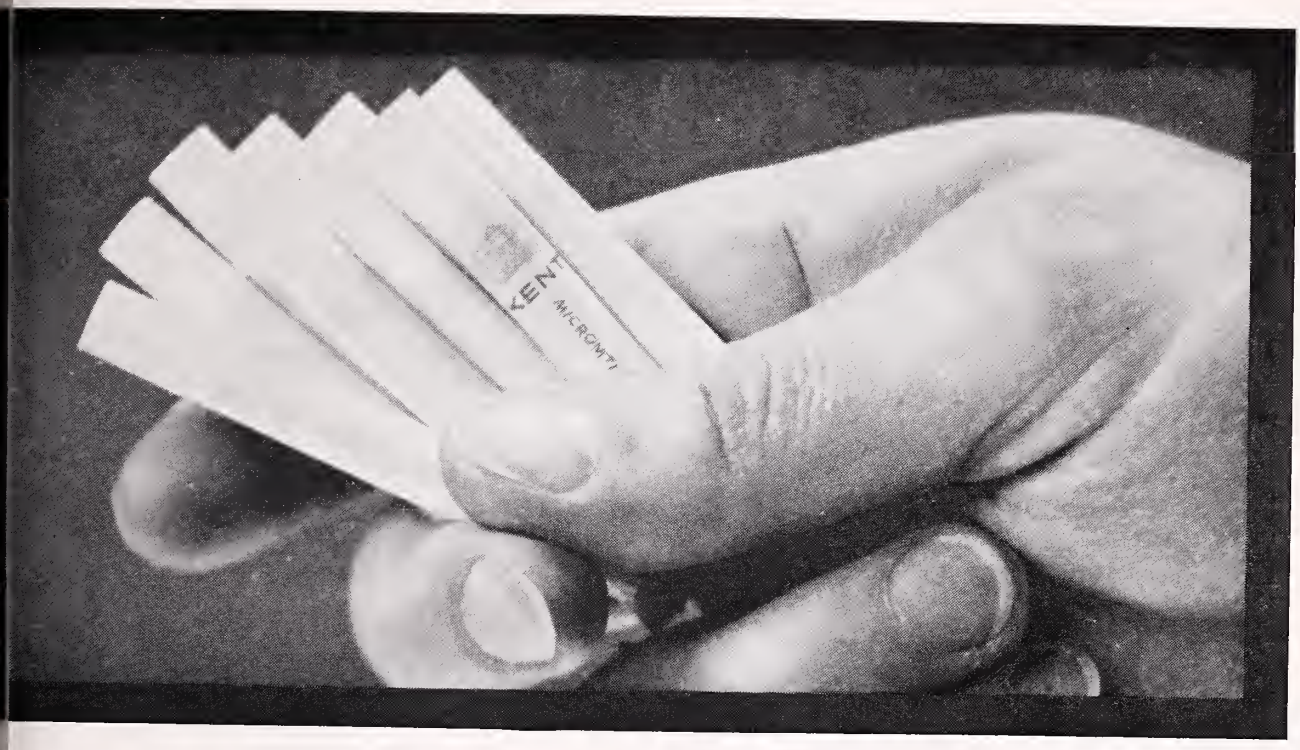
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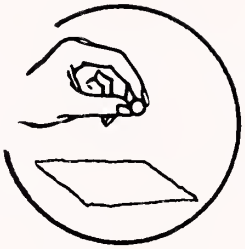
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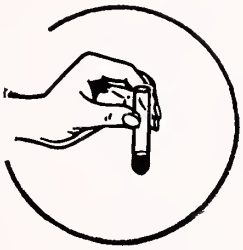
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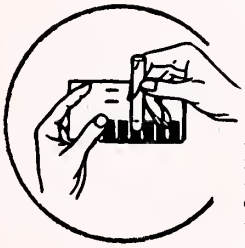
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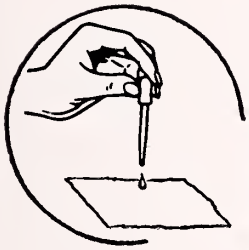
*Bumintest* Reagent Tablets present a simplified sulfosalicylic acid test for the detection of clinically significant amounts of albumin.





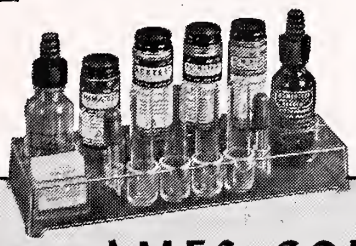
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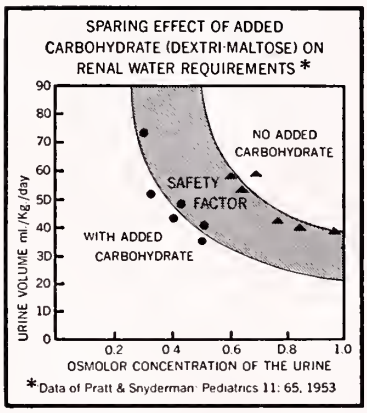
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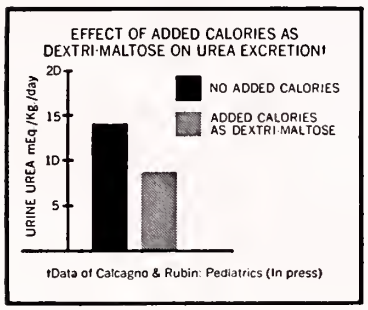
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1. Pratt & Snyderman: Pediatrics 11: 65, 1953; 2. Calcagno & Rubin: Pediatrics (in press); 3. Calcagno, Rubin & Weintraub: J. Clin. Investigation 33: 91, 1954; 4. Caoke, Pratt & Darrow: Yale J. Biol. & Med. 22: 227, 1950; 5. Gamble: J. Pediat. 30: 488, 1947; 6. Rappaport: Am. J. Dis. Child. 74: 682, 1947.

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# HAWAII MEDICAL JOURNAL

and

## INTER-ISLAND NURSES' BULLETIN

VOL. 13 JULY-AUGUST, 1954 NUMBER 6


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(ERGONOVINE MALEATE, U.S.P., LILLY)

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Number 6

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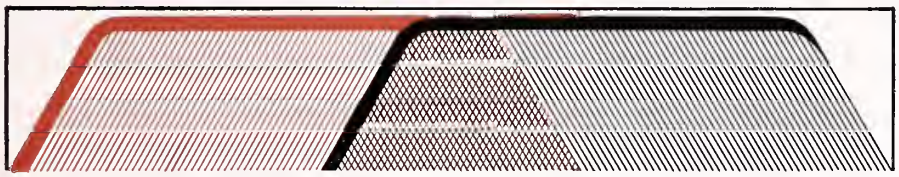
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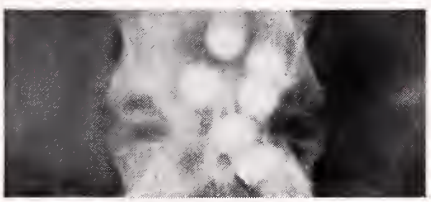
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# *assures 8-12 hours' sustained relief in hay fever*

*Outer layer* dissolves immediately providing rapid onset of relief

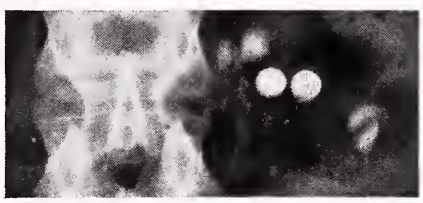


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*Unretouched x-rays.

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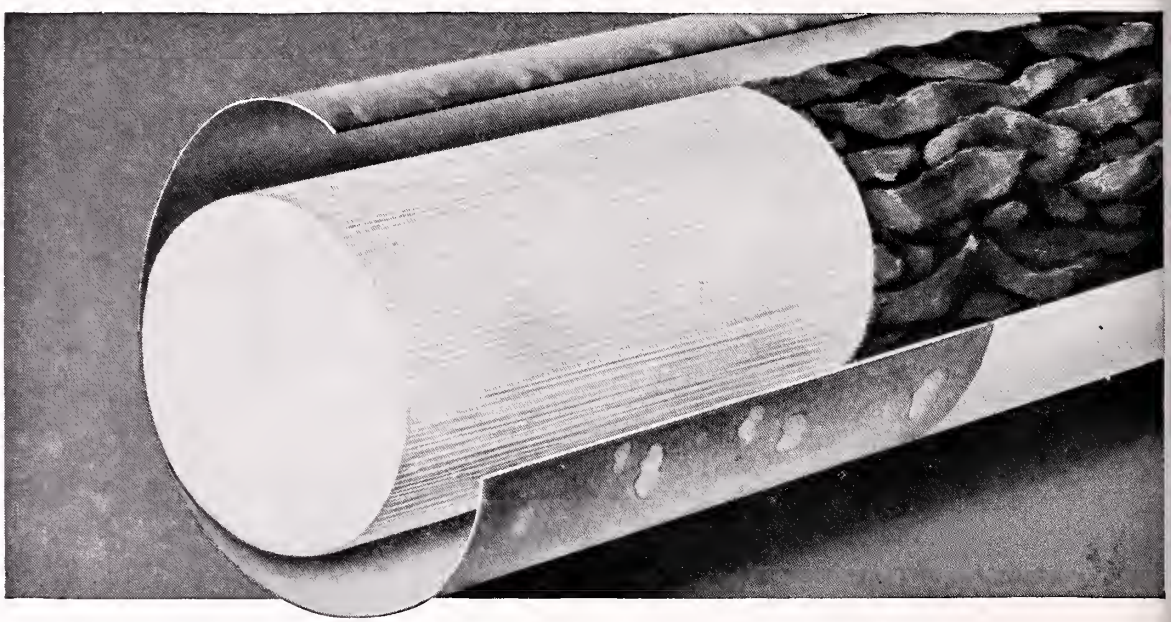
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# "Which Cigarette Shall I Choose?"

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OUTSELLS ALL OTHER FILTER TIP CIGARETTES COMBINED

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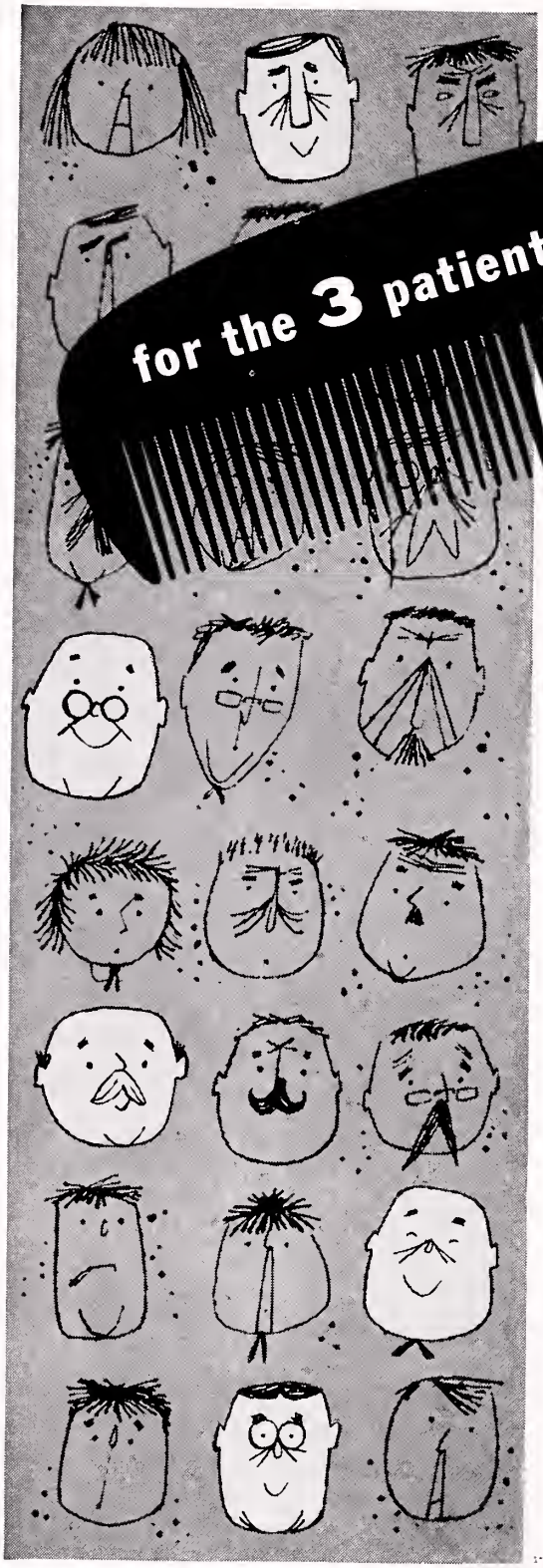
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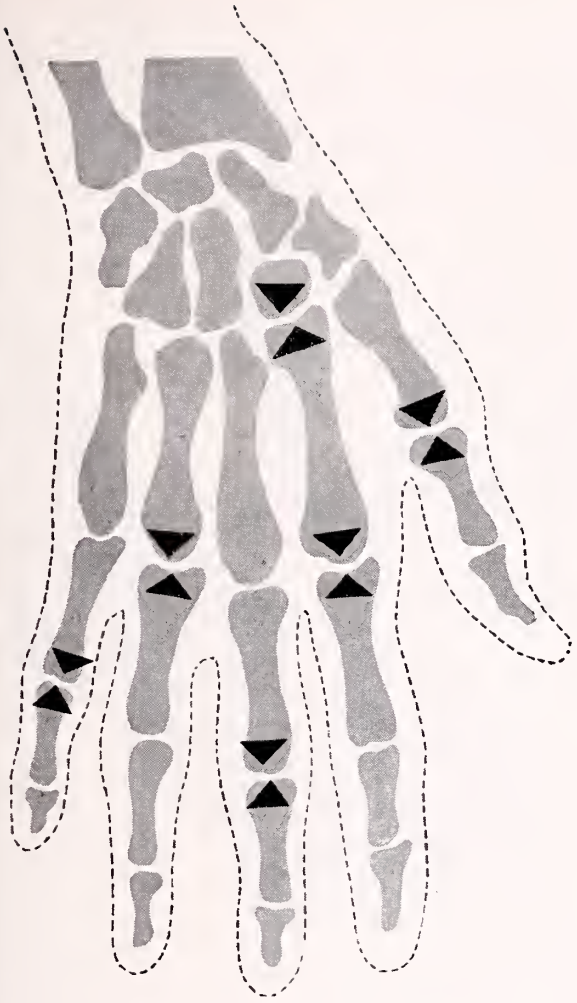
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SULFIDE *Suspension*

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1. Slepyan, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), *ibid.*, 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

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*in*
*arthritis*
*and allied*
*disorders*

**Rapid Relief of Pain**
usually within a few days

**Greater Freedom**
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functional improvement in a significant percentage of cases

**No Development of Tolerance**
even when administered over a prolonged period

# BUTAZOLIDIN

(brand of phenylbutazone)

Its usefulness and efficacy substantiated by numerous published reports, BUTAZOLIDIN has received the Seal of Acceptance of the Council on Pharmacy and Chemistry of the American Medical Association for use in:

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357



***an entirely***

***different view on antisepsis***

Bactericidal, yes! But that's not all that makes Zephiran chloride an outstanding antiseptic.

The power to penetrate crevices and folds...to spread to contaminated surfaces...to act rapidly on a wide variety of micro-organisms...characterizes the germicidal qualities of this antiseptic.

Zephiran chloride, as a cationic detergent, has marked wetting and penetrating activity because it reduces surface tension. Its dispersive power is a valuable adjunct to gram-negative and gram-positive bactericidal potency.

Supplied as Aqueous Solution 1:1000, bottles of 8 oz. and 1 U.S. gallon. Tincture 1:1000, tinted and stainless, bottles of 8 oz. and 1 U.S. gallon. Concentrated Aqueous Solution 12.8%, bottles of 4 oz. and 1 U.S. gallon (1 oz. = 1 U.S. gallon 1:1000 solution), must be diluted.

***for antisepsis with finesse***

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*". . . the gastric secretion is the immediate agent of mucosal tissue digestion. . . . Opposed to this stands the defensive factor . . . the two-component mucous barrier"*[1] *[the protecting layer of mucus and the mucosal epithelium].*



*Rotational gastroscopic views showing coating effect 1½ hours after administration of Amphojel.*[2]

## Causation – key to treatment in peptic ulcer

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AMPHOJEL—nonsystemic, nontoxic—provides time-proved *fundamental* therapy in peptic ulcer.

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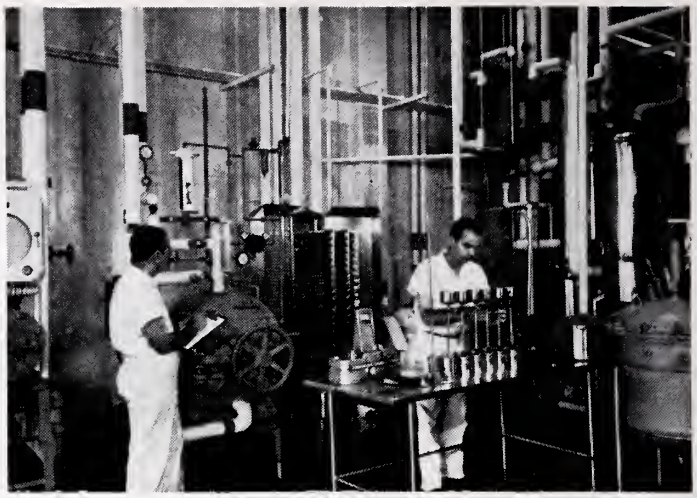
ALUMINUM HYDROXIDE GEL

*Supplied:* Liquid, bottles of 12 fluidounces
Tablets, 5 grain, boxes of 30, bottles of 100; and 10 grain, boxes of 60 and 1000

*References:* 1. Hollander, F.: Arch. Int. Med. *93*:107 (Jan.) 1954
2. Deutsch, E.: Scientific Exhibit, Gastroscopy, Interim Session A.M.A., St. Louis, December, 1953

Wyeth®
Philadelphia 2, Pa.

# How Carnation protects the baby's formula from farm to bottle



### Guards Your Recommendation Five Important Ways

**1.** Continuous research at Carnation Laboratories guards the purity and nutritive values of Carnation Milk. Here, also, new and improved processing methods are developed. Information gained through research is channeled to the Carnation Farms, to Carnation Plants throughout the country, and — through Field Service Men — to Carnation supplier dairy farmers from coast to coast.

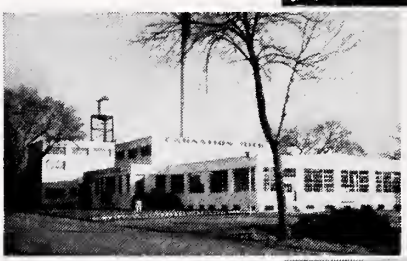


**2.** From the famous Carnation Farms near Seattle, dairy cattle from world champion bloodlines are shipped to supplier herds to help improve the Carnation milk supply.

**3.** Carnation supplier dairy herds are inspected regularly by Carnation Field Service Men. Only milk meeting Carnation's high standards is accepted.





**4.** Every drop of Carnation Milk is processed solely by Carnation, in Carnation's own plants, to Carnation's high standards, assuring constant high quality, uniformity.

**5.** Carnation store stocks are date-coded and inspected regularly by Carnation salesmen to assure uniform freshness and high quality.



## A NEW IDEA!

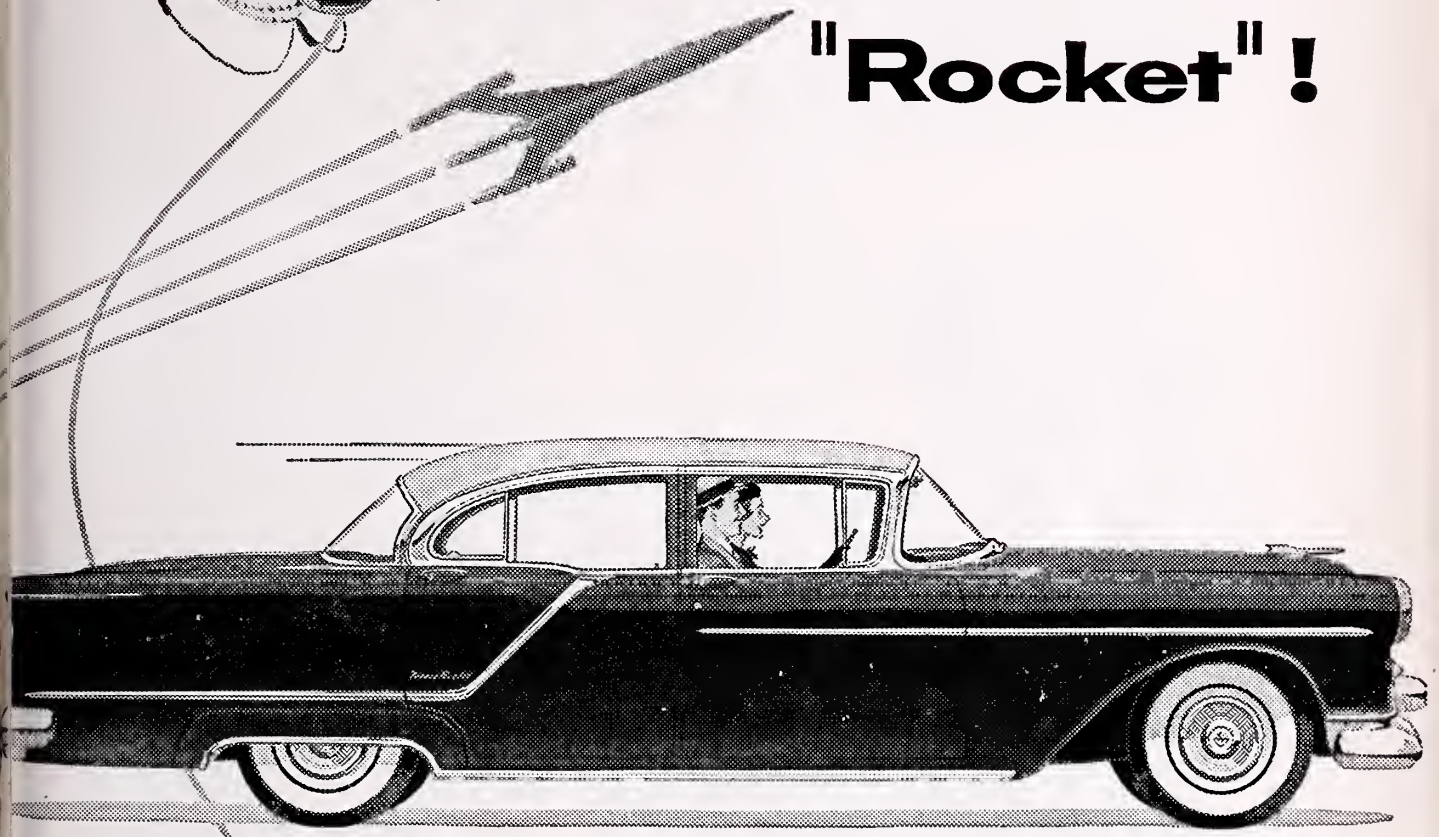
More ond more physicians are suggesting the use of recanstituted Carnation Milk during the tronsition from bottle to cup, to avoid digestive upsets and encouroge baby's ready acceptance of milk from the cup.



## The milk every doctor knows!



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*Ninety-Eight 4-Door Sedan. A General Motors Value.*

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You're busy. And perhaps you can't find time to come to our showroom. *But we can come to you—and we will!* All you have to do is pick up your telephone. Give us a ring and we'll give you a ride—in the car that's smashing Oldsmobile's all-time sales records. And when you take the wheel of this '54 "Rocket", you'll soon discover the reasons for the records. There's a new *view* . . . a new *ride* . . . and a new *feel.* But above all, there's new ACTION! For these new "Rockets" offer performance that outstrips even Oldsmobile's previous "Rocket" Engine cars—*and that's power!* Ring for *your* ride in a "Rocket". . . today!

"ROCKET" ENGINE

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## MURPHY OLDSMOBILE, LTD.

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The Model 207 **Ekotape** recorder introduces a **new** concept in audio-visual presentations. Used in conjunction with any automatic slide or strip film projector, this recorder is so easy to operate that the average person can make a presentation in short order, or change it at any time to fit individual situations. It completely eliminates the need for bell or "beep" tone or other distracting audible signals, and for the thumb-switch slide selector. In fact, after readying the eauipment and starting the **Ekotope,** the operator need do nothing further during the presentation.

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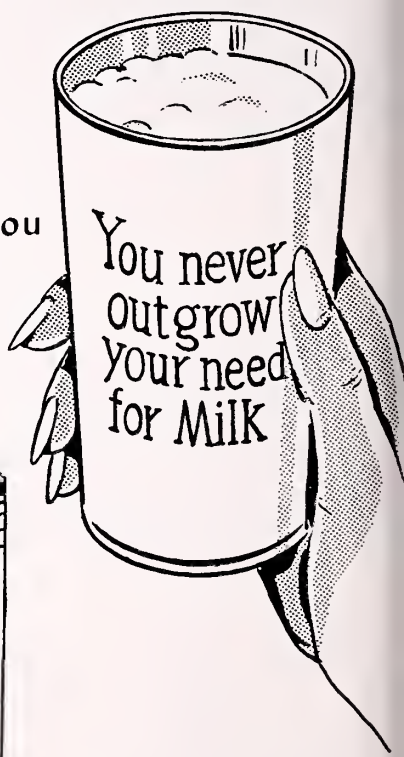
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| 1 | HELPS YOU SLEEP BETTER. |
| 2 | EASES NERVOUS TENSION. |
| 3 | ENDS CALCIUM STARVATION. |
| 4 | BUILDS STRENGTH, NOT FAT. |
| 5 | IMPROVES COMPLEXION. |







**It's a fact, too..**

**7 OUT OF 10 PREFER DAIRYMEN'S**

*Dairymen's Association, Ltd.*

*Honolulu - Kailua - Wahiawa*

VASCULAR HEADACHES
*Reminder #2*

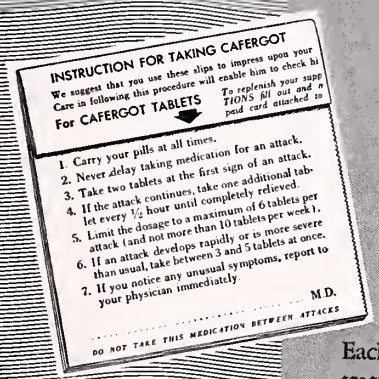
*WHEN...*
*the headache*

- *is of vascular mechanism*
- *has no underlying pathology*

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

# CAFERGOT
TABLETS

*Effective in 85 to 90% of the recurrent, throbbing headaches, e.g. migraine.*


INSTRUCTION FOR TAKING CAFERGOT

We suggest that you use these slips to impress upon your Care in following this procedure will enable him to check hi

For CAFERGOT TABLETS

To replenish your supp TIONS fill out and n paid card attached to

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3. Take two tablets at the first sign of an attack.
4. If the attack continues, take one additional tablet every ½ hour until completely relieved.
5. Limit the dosage to a maximum of 10 tablets per attack (and not more than 10 tablets per week).
6. If an attack develops rapidly or is more severe than usual, take between 3 and 5 tablets at once.
7. If you notice any unusual symptoms, report to your physician immediately.

M.D.

DO NOT TAKE THIS MEDICATION BETWEEN ATTACKS

*To be sure* of relief . . . *be sure* that your patient is following your directions* *exactly:*

1. Carry your pills at all times.
2. Never delay taking medication for an attack.
3. Take two tablets at the first sign of an attack.
4. If the attack continues, take one additional tablet every ½ hour until completely relieved.
5. Limit dosage to a maximum of 6 tabs. per attack.
6. If an attack develops rapidly or is more severe than usual, take between 3 and 5 tablets at once.
7. If you notice any unusual symptoms, report to your physician immediately.

Each Cafergot® Tablet contains 1 mg. of ergotamine tartrate and 100 mg. caffeine alkaloid.

Supplied: Bottles of 20 and 100 tablets.

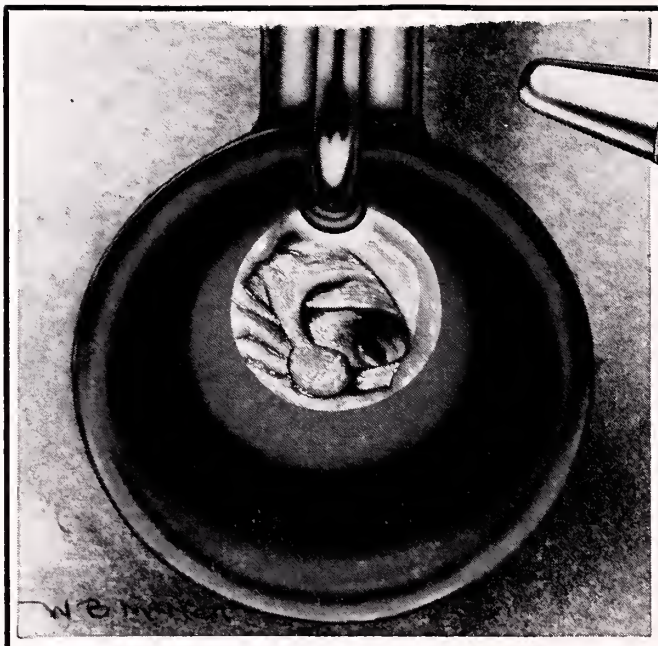
*Pads of Direction Slips (as above) are yours for the asking; write to: Sandoz Pharmaceuticals, Hanover, N. J.

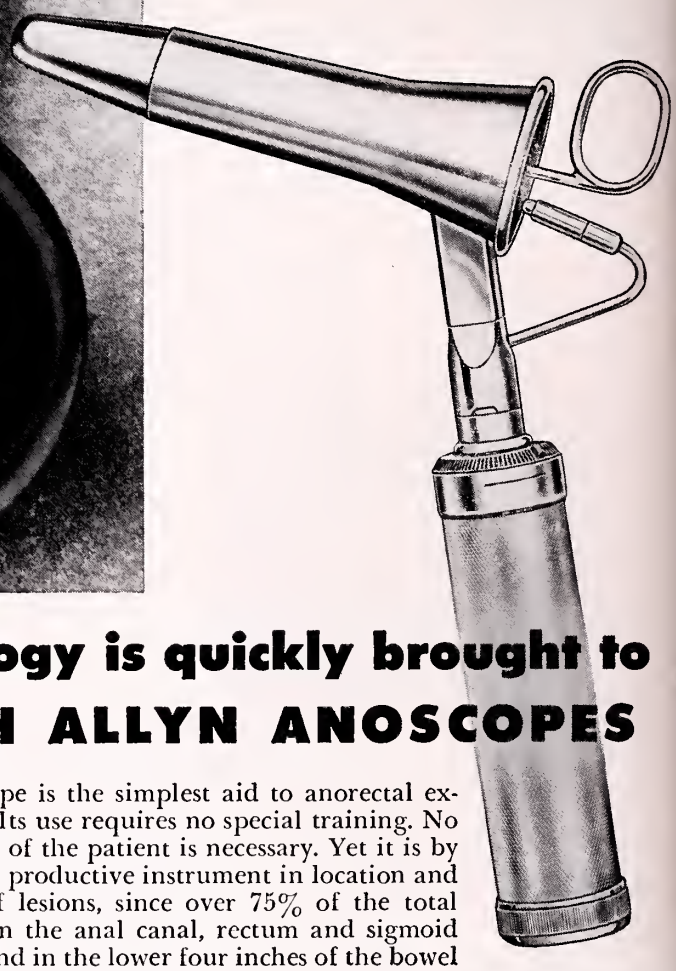
CAFERGOT SANDOZ VASCULAR HEADACHES

Sandoz PHARMACEUTICALS

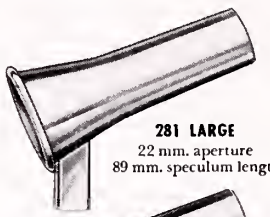
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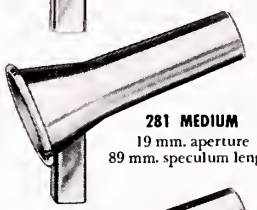




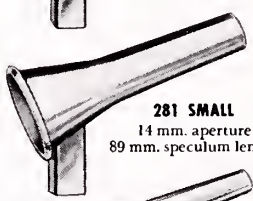
# Anorectal pathology is quickly brought to light with WELCH ALLYN ANOSCOPES



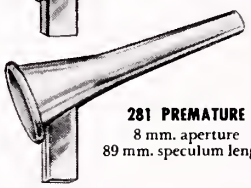
**281 LARGE**
22 mm. aperture
89 mm. speculum length



**281 MEDIUM**
19 mm. aperture
89 mm. speculum length



**281 SMALL**
14 mm. aperture
89 mm. speculum length

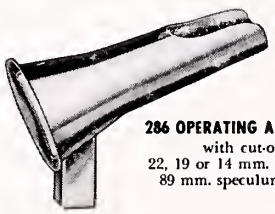


**281 PREMATURE**
8 mm. aperture
89 mm. speculum length

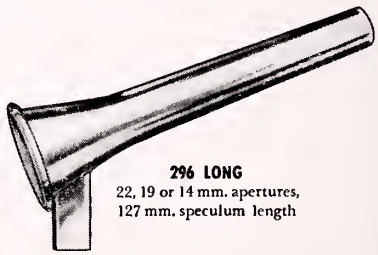
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| | *Vestibular damage % of patients* | | |
|---|---|---|---|
| | *Mild* | *Moderate* | *Total* |
| Streptomycin | 12 | 6 | 18 |
| Dihydrostreptomycin | 6 | 0 | 6 |
| Distrycin | 0 | 0 | 0 |

| | *Cochlear damage % of patients* | | |
|---|---|---|---|
| | *Mild* | *Moderate* | *Total* |
| Streptomycin | 0 | 0 | 0 |
| Dihydrostreptomycin | 12 | 3 | 15 |
| Distrycin | 0 | 0 | 0 |

**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.*

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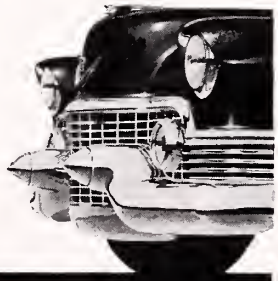
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# FREEDOM—OUR GUIDING LIGHT

EDWIN K. CHUNG-HOON, M.D., Honolulu

AT the end of the day, when the sun is rapidly sinking in the west and night advances suddenly upon us as it does in these Pacific islands, we frequently have a moment for reminiscing over the events of the day . . . at least, I often do. And many times I have asked myself: What is our mission in life? What is it that we search for? Why are we working so hard? And in the stillness of the night many answers can be heard. However, those that ring forth with the clarity of a bell tell us that our mission is to seek a life that abounds in justice and freedom. These are the verities we labor daily to preserve. And in our constant search for freedom we will find the beauty of living.



DR. CHUNG-HOON

Freedom is defined as that quality or state of being not subject to an arbitrary external power. Freedom is independence. Independence was fought for, created and secured in 1776, and Freedom has enjoyed a perpetual life in America ever since. It is the substance of our American Way of Life, the essential elements of which are the widely known Freedom of Speech, of Press, of Assembly and of Religion. This wonderful Way of Life grants to each of us the right to choose the place in which we wish to live, to choose our friends, to choose our butcher, our baker, our clothier; to choose the men and women to represent us in public office; and the right to choose our own physician. No one can deny that freedom of choice is the stimulus that creates incentive in the individual to improve the quality of his product and the quality of his service. Freedom of the patient to choose his own physician guards the inalienable right of a physician to attain any degree of success he is entitled to purely on the basis of merit. When this freedom of the patient is destroyed, the freedom of the physician is also destroyed.

Every so often there is an expressed desire in certain quarters favoring medicine by government. In addition to the destruction of individual initiative and the unfavorable alteration of the quality of medicine served to the general public under bureaucratic control, the cost of nationalized medicine to the taxpayer would be a financial burden unheard of in the annals of history. It is not generally known that the physician is repeatedly called upon to provide professional services to the indigent without compensation. In a previously concluded biennium the Territory of Hawaii spent nearly $1,750,000 for indigent care . . . and significantly, not one penny of that was paid to the physicians and surgeons who provided expert medical and surgical care to the several thousands of those indigent patients (except in the rural districts). The physician, however, has never sought to be personally compensated for those services which, if computed on the generally accepted hourly rate for medical services, would be tremendous. It is his contribution to humanity and he has been performing this public service since time immemorial. Those who cannot pay for private medical care are receiving the finest quality of medicine from the medical profession. Those who can afford to purchase private medical care prefer it that way, just as they do the ability to purchase any other commodity they need or desire. Free enterprise in medicine is as important to every American as it is to the physician. Nationalization of medicine has no place in our American Way of Life. We can only practice the principles of the arts and sciences of medicine, as outlined by that great medical genius Hippocrates, in the light of freedom.

Freedom in medicine is so integrated with freedom in every other field of endeavor that whatever threatens medical freedom becomes of vital concern to every one. Undoubtedly you will recall that the compulsory health insurance bill introduced in the last Congress was defeated by the voice of the people of America, who would not tolerate this threat to their freedom. Again we are confronted with legislation on a national level that may be even worse than the compulsory health insurance bill previously defeated, namely the Wolverton bills, which provide for reinsurance for prepaid medical plans and subsidies to any group, whether medical or lay, to establish clinics and hospitals. This all adds up to increased bu-

Presidential address to the ninety-eighth annual meeting of the Hawaii Medical Association, Honolulu, May 14, 1954.

reaucracy and federal control of medicine. The people of Hawaii have been saddled with a Workmen's Compensation Law that denies the patient the right to a free choice of physician. "House Bill 692," which passed both houses of the 27th legislature but died by pocket veto of the Governor, was designed to restore this freedom to the people. Employers and insurance carriers argued against the bill about as follows: (1) We pay the bill so we should choose the physician for the patient (this however is not an expression of any generosity on the part of the employer who is mandated by law to pay for the medical care of his injured employee, the expenses for which he deducts as business costs); (2) The employees would get poor service from their choice of physician, prolong their disability, and run costs up too high. The proponents of "House Bill 692" argued that the patient is entitled to a free choice of physician and that it is unAmerican to take away this vital freedom. When this Bill is reintroduced in the next legislature I am confident that it will pass, for freedom of the people cannot be defeated.

Freedom within the medical profession has been responsible for the progress that has occurred in the art and science of medicine throughout America. We have seen and experienced that phenomenal progress particularly in the past ten or twelve years. Sulfonamides, antibiotics, sulfones, anesthetics, ACTH, cortisone, improvements in surgical techniques and new laboratory tests have been developed and refined for the benefit of mankind—all shared with the peoples of the world. Even Hawaii has participated in this historical period of achievement in American medicine.

I can recall a beautiful morning in May in the year 1946. The sun was shining in all its brilliance on this early morning, and though the gentle Hawaiian trade winds were swirling through the coco palms, the little room that served as a dispensary seemed to be quite warm. It was warm with friendliness. An examining table was in the center of this room and against one wall were instrument cabinets. Against another wall was a contraption that resembled a bootblack's stand, with two chairs on a platform and two foot rests in front of each chair. This was a dressing stand where patients would seat themselves and prop their feet on the foot rests so that the nurse could dress the many sores of their lower extremities. It made it easier for the nurse and it certainly saved her back during the long hours attending 30 to 40 patients each morning. A tray loaded with sterile syringes was on a stand near the examining table. Just outside of the dispensary, seated on the lanai, were several patients waiting to be called. Two nurses were busily making the final arrangements of the room and soon the day's work was to begin.

This setting of American medicine at work was in Kalihi Hospital at the foot of Puuhale Road in the Kailihi-kai district of the City of Honolulu. The dispensary was a part of this hospital. The nurses were among the finest in the Territory. The patients seated on the lanai were afflicted with leprosy in advanced stages. History was in the making as the first patient with heavy lepromatous leprosy climbed upon the examining table to lie flat on his back and receive the first intravenous injection of sulfone in the hope that it would free him of his disease. Today is eight years later and that man with advanced lepromatous Hansen's disease exhibiting tumors and infiltrations over his total skin area who had a life expectancy of no more than two years at that time, is now well and healthy and free of evidence of his disease. He will live to a ripe old age if he doesn't get killed on one of Honolulu's highways. That contraption that looked like a bootblack stand is no longer a necessity, for the medicines now available keep the leprous patient free of ulcers. And into the pages of time has been written an exciting story of American medicine at work.

Could this have occurred behind the iron curtain? I am sure it could not. Persons even much healthier than our patient have been put to death in Communist countries to relieve the burden of the State; surely that would have been his fate. But in our country he was even given the freedom to choose the kind of treatment he desired. Only in the brilliant light of Freedom could this drama of service to humanity be performed.

In recent years with ever increasing frequency we have seen nations fall and become dismembered under the hammer and sickle of Communism. Once under the influence of Communistic control, people are denied their rights and stripped of their freedom. They are given the Communist "brain washing" treatments until the ability to think, speak and act as individuals is completely lost. For example: Not so long ago East German Communists, whose puppet regime was granted "sovereignty" by the Soviet, announced that general elections would be held. Voters would be allowed to vote only for candidates selected by the "National Front," which is made up of the Communist Party, its youth organization and collaborationist parties. What mockery of the election system! Where is there freedom of government when the will of the people is stifled?

Voluntary health insurance is Freedom's method

for providing ways and means to finance catastrophic illness. Voluntary health insurance is an example of the American system of free enterprise perpetuating the right of every individual to make his own plans for the protection of himself and his family in times of illness. It represents individualism so typical of the American people. It has been recently reported that 58% of the population of America now enjoy some form of health insurance. This is quite an increase over the 9% who were covered just prior to World War II. Here in Hawaii our answer to socialized medicine or panel medicine is the Hawaii Medical Service Association (HMSA). One out of every 6 persons in the territory is a member of HMSA. HMSA is often referred to as the "doctors' plan," and it is. Forty percent of the membership of the board of directors is composed of physicians representing the various county medical societies of the Hawaii Medical Association. The balance of the membership on the board of directors of HMSA is composed of men skilled in business and business management, leaders from the field of education, from the clergy, from government and from the field of hospital administration. In his annual report HMSA President J. A. Pell showed that out of the dues income dollar only 11.8% was spent for operating expenses. This is most significant. Eighty three and two tenths percent of the income was paid out in benefits to the assured; the balance of 5% was held in the membership's general reserves. Mr. Pell further stated: "Our association is making a careful study of 'major medical expense' programs, locally and on the mainland, and it appears that with the continued full support of our participating physicians and hospitals HMSA can underwrite such plans. Such a program is designed to provide for extreme catastrophic illness, in excess of the HMSA's basic coverage, up to $5000.00, with certain deductibles to be paid by the member." I can certainly assure the President of the HMSA that the medical profession of the territory will continue to give its full support to this fine medical service association which gives the patient a free choice of physician and a free choice of hospital.

Freedom carries with it personal responsibility, and the physician has a definite responsibility to his patient, not only medically but also socio-economically. With the rapidity of development of medical skill and knowledge, and the constantly increasing specialization within the profession, the necessity for two or more physicians to participate in the treatment of the patient is abundantly apparent. If the patient presents an intricate surgical problem, the general physician seeks the assistance of a surgeon qualified to master that particular surgical condition. They examine the patient, tell him of his troubles and about the surgery that has to be done. The patient inquires about cost but they say: "Forget it." The patient does. Together they labor in the best interests of the patient. The general physician prepares him, often making the diagnosis; the surgeon confirms the diagnosis or makes it if it was not already made and then he performs the operation with the finest skill and care at his command.

After the operation the surgeon and the general physician continue to render care and treatment to the patient until he has fully recovered. During the entire association of these two—the surgeon and the general physician—they have talked about gall bladders and gall stones and icterus and whole blood and common ducts and duodenums—but not one word was said about the almighty dollar! Nothing was said about fees—how much is the surgeon's bill; the hospital bill; the general physician's bill. To the patient they said even less. He asked about fees before the operation but they said: "Don't worry about fees. We want to get you well first. So forget it." How unfortunate for the physician! Comes the end of the month the surgeon says to his bookkeeper: "Oh, by the way, send Mr. Blank a bill 'for services rendered' $500.00." About that time the general physician begins to think: "I wonder how much Dr. Surgeon is charging Mr. Blank. Oh, well, it's none of my business. I'll send him a bill 'for services rendered' $175.00." When the patient receives the bills he hits the ceiling. The hospital bill for $585.00 is understandable. It is itemized. "But," he screams "What in the world is this $500.00 from the surgeon and $175.00 from the general physician for?" Would it not have been better to have discussed fees in the beginning? Would it not have been better to have itemized the bill? I am certain of that. As a means toward the betterment of patient-doctor relations I personally solicit every member of the Association to review charges for services rendered in advance of performing the services.

During World War II and shortly afterward we used to say: "I want that car, that radio, that washing machine," and we would pay for them without batting an eye. Nowadays we say: "How much is that car, how much is that television set?" and then we make our plans to pay for those items. People also ask about fees for medical services, and they have a right to know before treatment is started. A reasonable estimate of the fee can always be given in every case. They have a right to an itemized bill from every physician. Service to humanity is the mission of the medical profession. So well do we know that medicine is

our business that much too often we forget or ignore the fundamentals of medical economics. And yet a sound economic foundation is so vital to the success of every physician—success personally, success for the medical profession generally.

Freedom also implies personal responsibility of a physician to his colleagues and to his county and national medical societies. A physician must depend upon himself, his skill, his knowledge and his judgment for any decisions on diagnosis, treatment and care of his patient. This singular characteristic of the medical profession develops within the physician individualistic thinking. This is a very fine quality and is typical of the freedom in medicine that we enjoy under our American Way of Life. However the very nature of this individualism renders the physician less able to act collectively on problems of vital concern to the medical profession as a whole. Engrossed in the problems of the sick and injured the physician finds himself intensely absorbed in the complexities of the diseases or injuries that challenge his skill and judgment. Problems in the business field of medicine, problems of a socio-economic nature, and problems of public relations naturally receive very little of his attention, and the "let-George-do-it" attitude is frequently visible through the physician's cloak of individualism.

As individual physicians we may be fine fellows to our patients, and yes, even to the general public. But as a unit the medical profession seems to be losing the position of respect and honor that was traditionally theirs. Medicine's mistakes make excellent copy for the press and enhance reader interest. You have heard the sob stories of the "get-rich-quick" radio and television shows which paint the doctor as the villain who makes it economically impossible for the unfortunate patient to secure medical help. We know that such is not true. Medical care is available to all who need it through private, governmental or voluntary agencies. There isn't a physician today who does not give long hours of his time and the best quality of medical service to charity or indigent patients. And yes, the physician donates his money also to charitable organizations for the care of the indigent sick.

In every branch of society and in every profession too one is bound to find a scoundrel. The medical profession has been accused of having within its ranks some physicians who have little respect for ethics and who gouge the public by charging their patients all that the traffic can stand. It is time that we got together as a collective body, not as a group of individualists, to ferret out those physicians whose misbehavior has brought discredit upon the profession. Therapeutic measures must be employed to correct these deficiences and strict adherence to the principles of ethics must be enforced.

In this atomic age where progress is being made at a very fast pace we can ill afford to continue in the rut of complacency. It is incumbent upon each of us to dismount the "high horse" and take stock of our present precarious position . . . and to do something about it.

We can advance our cause by producing visible evidence of our sincerity and visible evidence of progress, not only of progress in the arts and sciences of medicine but also in the field of public relations and of socio-economic endeavor. The modesty of the medical profession restrains us from publicizing the many good deeds performed in the interest of humanity. We must publicize these facts and tell the public what we are doing in medicine. By your decrees and directives limiting the powers of your officers and committees little can be done at an association level in the performance of acts designed to promote good public relations and to render decisions on a collective basis concerning Medicine's relations with management, labor, insurance carriers, hospitals, and the public.

The responsibility for performing good public relations that will benefit you and in the end benefit the medical profession as a whole is yours, and yours alone. Good public relations, good relations with any organization and such acts designed to promote good will, begin right with YOU in your office. Therefore, every physician must remember that he as an individual is his best public relations agent and he must remember to handle his patients diligently, wisely, and skillfully not only medically but also socio-economically.

Remember . . . the American Way of Life affords you Freedom in medicine. Freedom provides the climate for the physician to develop individualistic thinking, to promote his initiative, and to continue to improve the quality of Medicine. You must remember also that Freedom carries with it Personal Responsibility . . . responsibility to yourself, responsibility to your colleagues, responsibility to your county and national medical societies, responsibility to the people of your community, responsibility to your family, and responsibility to all of your patients. Freedom is our Guiding Light.

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# RACIAL INCIDENCE OF CANCER IN HAWAII

## A Study of 3,257 Cases of Malignant Neoplastic Disease

W. B. QUISENBERRY, M.D., I. L. TILDEN, M.D., AND J. L. ROSENGARD, M.D., Honolulu

FOR many years physicians in Hawaii have suspected that differences exist in the incidence of cancer in our various racial groups, but little has been done to prove or disprove these impressions. The morbidity study upon which this report is based was started in June, 1948, under the sponsorship of the Hawaii Medical Association, the Hawaii Cancer Society, and the Territorial Department of Health. Hospital records of patients with neoplastic disease have been reviewed from 1944 to 1952 inclusive in most of the major hospitals on all of the islands. Approximately 4,000 records have been reviewed to date and 3,257 of these were regarded as acceptable cases of malignant neoplastic disease by the physicians working on the project. The diagnosis in 88% of these 3,257 cases was proven by histologic examination; in the remaining 12%, there was convincing clinical, radiological or laboratory evidence to confirm the diagnosis. This report will be limited to a brief consideration of stomach, breast, liver and lung cancer in the various racial groups in Hawaii.



DR. QUISENBERRY

### Cancer of the Stomach

In 1948 McClanahan and co-authors[1] found that 48% or almost one-half of 52 patients with gastric cancer treated at the Queen's Hospital over an eighteen-month period were Japanese, a racial group comprising only one-third of the population of the Territory. (The percentage of Japanese in the population today is estimated at 37.7%.)

In 1949 Steiner[2] studied 35,293 necropsy records at the Los Angeles County Hospital, which included 741 cases of gastric carcinoma. Twenty-one of these were in Japanese, constituting 36.2% of all malignant tumors in this racial group. In the large Caucasian group, only 11.8% of all malignant tumors were gastric in origin. According to Steiner, Nagayo found that gastric cancer comprises 42.68% of all carcinomas in a necropsy series at the Pathological Institute of Tokyo Imperial University, and that similar high necropsy figures for this type of cancer had been reported from other Japanese cities.

In 1951 Strode[3] reported on 500 gastric resections performed by him in Hawaii and found that operations for gastric carcinoma were twice as frequent in Japanese as in other races, and that in other races operations for duodenal ulcer were two and one-half times more frequent than in the Japanese group.

In a recent study, Rhea[4] concluded that Japanese males 45 years of age and over in Hawaii have a significantly higher mortality rate from gastric carcinoma than non-Japanese males of the same age group. This study was based upon 2,201 deaths from cancer recorded by the Bureau of Health Statistics of the Territorial Department of Health from 1948 to 1952 inclusive. Although subject to the errors inherent in data derived from death certificates, the high mortality rate of gastric carcinoma in the Japanese male compared with the non-Japanese male was striking and was found to be significant by valid statistical tests.

TABLE 1.—*Per Cent Gastric Cancer of All Cancers Within Each Race by Sex, Territory of Hawaii, 1944-1952.*

| | MALE | FEMALE |
|---|---|---|
| All Races | 22.6 | 11.2 |
| Hawaiian & Part-Hawaiian | 18.3 | 11.8 |
| Caucasian | 13.6 | 5.5 |
| Chinese | 12.4 | 5.4 |
| Japanese | 34.5 | 20.1 |
| Filipino | 5.7 | 2.9 |
| Other* | 28.0 | 5.7 |

* Puerto Rican, Korean, Negro, Samoan, Indian.

Our study of 3,257 cases of cancer included 565 cases of carcinoma of the stomach, constituting 17.3% of the total. Table 1 shows the percentage distribution by sex and by race. It should be noted that: (1) gastric cancer in all races comprised 22.6% of all cancer in the male and only 11.2% of all cancer in the female; (2) gastric carcinoma made up 34.5% (over one-third) of all cancer in the Japanese male and 20.1% of all cancer in the Japanese female; (3) the Hawaiian–Part-Hawaiian group ranked second, with gastric cancer making up 18.3% of all cancer in the male and 11.8%of all cancer in the female; and (4)

Read before the ninety-eighth annual meeting of the Hawaii Medical Association, Honolulu, May 14, 1954.

[1] McClanahan, B. J.; Mitchel, J. A.; and Milliken, H. E.: Carcinoma of the Stomach in Hawaii; A Review of 121 Gastric Lesions at The Queen's Hospital; HAWAII MED. J. 8:32 (Sept.-Oct.) 1948.

[2] Steiner, P. E.: Etiologic Implications of the Racial Incidences of Gastric Cancer, J. Nat. Cancer Inst. 10:429 (Oct.) 1949.

[3] Strode, J. E.: Observations on Cancer of the Stomach in Hawaii; A Study of 140 Consecutive Cases Coming to Surgery; HAWAII MED. J. 10:173 (Jan.-Feb.) 1951.

[4] Rhea, T. R.: A Comparative Study of the Mortality from Gastric Cancer in Hawaii, HAWAII MED. J. 13:107 (Nov.-Dec.) 1953.

the Caucasian group was third with cancer of the stomach constituting 13.6% of all cancer in the male; 5.5% of all cancer in the female.

In percentage of total cases, then, Japanese men in this study had about twice as much gastric cancer as Hawaiian, Part-Hawaiian, and Caucasian men. About the same proportion holds true for the women of these three races although, as already mentioned, gastric carcinoma percentage-wise was more than twice as frequent in the male. The number of cases in the other racial groups is too small to permit conclusions.

The incidence rates of gastric cancer per 100,000 population, broken down by sex and race, are shown in Table 2. The incidence rate for males of all races is over twice the female rate for all races. The Japanese male rate (29.1) is considerably greater than the male rate for all races (17.8), the male rate for Caucasians (16.6), and the male rate for the Hawaiian and Part-Hawaiian group (9.6).

TABLE 2.—*Incidence Rates Per 100,000 Population for Gastric Cancer by Sex and Race, Territory of Hawaii, 1944-1952.*

| | BOTH SEXES | MALE | FEMALE |
|---|---|---|---|
| All Races | 13.3 | 17.8 | 8.4 |
| Hawaiian & Part-Hawaiian | 8.6 | 9.6 | 7.7 |
| Caucasian | 11.0 | 16.6 | 6.4 |
| Chinese | 8.4 | 11.4 | 5.5 |
| Japanese | 20.7 | 29.1 | 12.1 |
| Filipino | 1.8 | 2.3 | .6 |
| Other* | 17.6 | 28.2 | 4.3 |

* Puerto Rican, Korean, Negro, Samoan, Indian.

TABLE 3.—*Per Cent Breast Cancer of All Cancers Within Each Race and Incidence Rates Per 100,000 Population by Race, Territory of Hawaii, 1944-1952.*

| (FEMALE ONLY) | % OF ALL CANCERS | RATE PER 100,000 POPULATION |
|---|---|---|
| All Races | 19.2 | 14.3 |
| Hawaiian & Part-Hawaiian | 17.6 | 11.5 |
| Caucasian | 28.7 | 33.5 |
| Chinese | 18.2 | 18.2 |
| Japanese | 11.9 | 7.1 |
| Filipino | 11.8 | 2.4 |
| Other* | 10.0 | 8.6 |

* Puerto Rican, Korean, Negro, Samoan, Indian.

### Breast Carcinoma

In 1938 one of us[5] reviewed 66 cases of carcinoma of the breast and six borderline malignancies treated at The Queen's Hospital between 1922 and 1936 inclusive. Sixty-four per cent of these patients were Caucasian, 18% were Hawaiian and Part-Hawaiian, and only 7% were Japanese. The hospital admission ratio between Caucasian and Japanese patients during the same period of time was 2:1 while the breast cancer ratio between Caucasian and Japanese women was 9:1, indicating that breast cancer was less common in Japanese women than in women of other races.

In this study there were 289 cases of breast carcinoma constituting 19.2% of all cancer in women. Table 3 shows that in Caucasian women 28.7% (over one-fourth) of all cancer was mammary; in Hawaiian and Part-Hawaiian women the breast accounted for 17.6% of all cancer; and in Japanese women, it accounted for only 11.9% (about one-tenth) of all cancer.

The incidence rates of breast cancer per 100,000 population are also shown in the table and tell a similar story. Caucasian women had an incidence rate of 33.5; Hawaiian and Part-Hawaiian women a rate of 11.5; and Japanese women a rate of only 7.1. For all races the incidence rate of breast cancer was 14.3 per 100,000 population.

### Primary Carcinoma of the Liver

It has been known for many years that primary cancer of the liver has a peculiar geographic distribution. It is rare in Europe and the United States, but is common in some parts of China, Malaya, and South Africa.[6] It is also known that a definite relationship exists between cirrhosis and primary liver carcinoma. Marnie[7] presented a report in 1953 on 12 cases of primary carcinoma of the liver seen at The Queen's Hospital between 1947 and 1952, and emphasized that certain racial groups in Hawaii are particularly susceptible to primary hepatic malignancy. Wilbur[8] and his group at Stanford studied 49 cases and concluded that the most important coexisting or perhaps contributing factor in the development of primary carcinoma of the liver is antecedent damage to the liver. In most instances this is manifested by the presence of cirrhosis in all degrees from mild, so-called limited cirrhosis, to the far-advanced atrophic cirrhosis of Laennec.

The present group of 3,257 cases included 49 cases of primary carcinoma of the liver. Table 4 shows the percentages and incidence rates per 100,000 population broken down as to sex and race. It should be noted that the number of cases per 100,000 population is 4.8 for Filipinos, which is much higher than any other race and more than twice the rate of 1.9 for males of all races.

### Bronchogenic Carcinoma

So far as we know, there have been no published studies on racial differences in the incidence of lung cancer.

[5] Tilden, I. L.: Carcinoma of the Breast in Hawaii, Transactions of Hawaii Territorial Med. Assn., May, 1938.

[6] Boyd, W.: A Textbook of Pathology, Ed. 5, Lea & Febiger, Philadelphia, p. 561.

[7] Marnie J. G.: Primary Carcinoma of the Liver: A Statistical Review of Twelve Cases Seen at The Queen's Hospital 1947 to 1952, HAWAII MED. J. 13:113 (Nov.-Dec.) 1953.

[8] Wilbur, D. L.; Wood, D. A.; and Willett, F. M.: Primary Carcinoma of the Liver, Ann. Int. Med. 20:453 (March) 1944.

TABLE 4.—*Per Cent Cancer of Liver of All Cancers Within Each Race by Sex and Incidence Rates Per 100,000 Population by Sex and Race, Territory of Hawaii, 1944-1952.*

| | Male | | Female | |
|---|---|---|---|---|
| | *Per Cent of All Cancers* | *Rate Per 100,000 Population* | *Per Cent of All Cancers* | *Rate Per 100,000 Population* |
| All Races | 2.4 | 1.9 | .5 | .4 |
| Hawaiian & Part-Hawaiian | 4.0 | 2.1 | .4 | .2 |
| Caucasian | .7 | .7 | .2 | .2 |
| Chinese | 2.2 | 1.8 | 1.4 | 1.2 |
| Japanese | 1.0 | .9 | .6 | .3 |
| Filipino | 12.0 | 4.8 | .... | .... |
| Other* | 1.9 | 1.7 | ... | .... |

* Puerto Rican, Korean, Negro, Samoan, Indian.

There were 205 cases of bronchogenic carcinoma in our study and Table 5 gives the percentages and the incidence rates per 100,000 for the various races. In males of all races, bronchogenic carcinoma accounted for 9.7% of the total number of cases, and in females of all races only 2.3% of all cases were lung carcinomas. In Hawaii, therefore, males have slightly more than four times as much lung cancer as do females. In the male, bronchogenic carcinoma ranks third behind large bowel with 13.4% of all cases, and stomach with 22.6% of all cases. During the period of this study, therefore, cancer of the lung did not have anywhere near the frequency that it now has in many centers in the mainland United States.

In comparing the three major ethnic groups, Hawaiian and Part-Hawaiian males had the highest percentage of lung cancer in their racial group —12.4%; Caucasian males next with 10% of the total; and Japanese males have the lowest percentage of this type of cancer—8.5%. The incidence rates probably give a more accurate picture, showing that Caucasian males with a rate of 12.1 per 100,000 have a significantly greater rate than males as a whole, considerably more than the Hawaiian group males (6.6) and the Japanese males (7.2). The female rates for all races are low and there are no significant racial differences.

## Comment

We believe that the figures presented here are fairly reliable because 88% of the 3,257 cases had histologic confirmation of the diagnosis. In the gastric cancers, 78% were confirmed by microscopic examination; and in the remaining cases there was convincing radiological and clinical evidence, often including surgical exploration of the abdomen. Ninety-five per cent of the breast cancers were confirmed histologically, 90% of the primary carcinomas of the liver, and 86% of the bronchogenic carcinomas.

TABLE 5.—*Per Cent Bronchus and Lung Cancer of All Cancers Within Each Race by Sex and Incidence Rates Per 100,000 Population by Race and Sex, Territory of Hawaii, 1944-1952.*

| | Male | | Female | |
|---|---|---|---|---|
| | *Per Cent of All Cancers* | *Rate Per 100,000 Population* | *Per Cent of All Cancers* | *Rate Per 100,000 Population* |
| All Races | 9.7 | 7.6 | 2.3 | 1.7 |
| Hawaiian & Part-Hawaiian | 12.4 | 6.6 | 3.3 | 2.2 |
| Caucasian | 10.0 | 12.1 | 1.7 | 2.0 |
| Chinese | 11.7 | 10.8 | 2.7 | 2.4 |
| Japanese | 8.5 | 7.2 | 2.3 | 1.3 |
| Filipino | 11.4 | 4.6 | 5.9 | 1.2 |
| Other* | 6.5 | 6.8 | 1.4 | 1.1 |

* Puerto Rican, Korean, Negro, Samoan, Indian.

The figures have not been analyzed by population age groups in the various races, and this should be done. For example, if there are more Japanese people in the older population than people of other races, one would expect to find a higher incidence of cancer generally in this racial group and a correspondingly higher incidence of cancer of specific sites as compared with other races. It is our opinion, however, that such differences, if indeed they actually exist, could not possibly account for the striking racial differences in the incidence of gastric, breast, liver, and lung cancer.

The reasons which have been advanced for these racial differences are highly speculative. So far as the breast is concerned, it has been suggested for years that the lactation habits of Japanese women (who tend to have large families and to nurse their children for long periods of time) may account for their relative immunity to breast carcinoma as compared with Caucasian women. MacDonald[9] studied 2,636 cases of breast cancer and thinks it entirely possible that the increasing incidence of breast cancer in "civilized" women may be due in large measure to complete or partial failure of lactation, and that a full period of lactation in child-bearing women seems to offer a degree of protection against the subsequent development of carcinoma of the breast. In this respect it is of interest that many experienced physicians in Hawaii believe that the incidence of breast cancer is increasing in younger Japanese women born in Hawaii who may have acquired the child-bearing and lactation habits of their Caucasian sisters.

In the case of primary carcinoma of the liver, one should not assume that Filipinos have inherited a predisposition to liver cancer as an inborn racial characteristic; rather, one should examine their environment, paying particular attention to their working and eating habits in an effort to discover etiologic factors.

It is apparent that important research possibilities exist here in Hawaii, which could be designed to try and determine the reasons for the differences in the incidence of cancer in our various racial groups. Such studies are now being planned.

[9] MacDonald, I.: Mammary Carcinoma: A Review of 2,636 Cases, Surg. Gyn. & Obst. 74:75 (Jan.) 1942.

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# A SUCCESSFUL TREATMENT FOR INFANTILE ECZEMA

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ANY doctor doing general practice, pediatrics, or dermatology is faced from time to time with the problem of treating a well-developed case of infantile eczema. There are few more trying problems to handle. Even the potent new agents, ACTH and cortisone, are variable in their results, in addition to being expensive and productive of undesirable side-reactions.



DR. NANCE

The title of this article was purposely chosen to excite interest. Those who are expecting to hear of a new injection, medicine, or all-curative salve are doomed to disappointment. The treatment may be summarized in one sentence: "The only successful treatment of infantile eczema is prevention." The following case histories will serve as illustrations:

## Case Reports

CASE 1.—S. G., a Caucasian girl, was first seen at the age of 5 months. She had been bottle fed from the day of birth. Her mother was an asthmatic. At one month of age, cereal was added to her diet, because "she seemed to be hungry all the time." The diet was expanded by the age of two months to include several fruits, vegetables, and meats, and "even this didn't keep her satisfied." At the age of 3 months, eczema appeared on the cheeks: within a month it covered most of the body. During this month the formula was changed successively to goat's milk and soy bean milk without benefit. Other foods were continued as before. She was a miserable specimen at 5 months, covered from head to foot with secondarily infected eczema. I will not bore you with the details of the futile treatments tried until her symptoms mercifully abated at the age of 16 months.

CASE 2.—E. P., a Filipino girl, was under continuous care from birth. Her older brother, first seen at the age of 2, was still a severe eczema problem at the age of 3. E. P. was initially breast fed, with an evaporated milk supplement started at 2 weeks gradually replacing an insufficient breast supply. At one month of age, the mother stated she was "hungry all the time," but closer questioning revealed that she was uncomfortable immediately after feedings when her stomach was full. Stool specimens showed much mucus containing eosinophiles. On a diagnosis of allergic colic, the formula was changed to evaporated goat's milk, and the symptoms subsided. No complementary foods were started. At the age of 3 months, eczema appeared on the cheeks. Despite the fact that her gastrointestinal symptoms had not recurred, the formula was changed to soy bean milk. Within one week the eczema cleared. Local treatment given was Mazon ointment on one cheek and vanishing cream on the other; both cheeks cleared equally well.

No complementary foods were started until the age of 4 months; at that time rice cereal was cautiously added to the diet. During the rest of her first year, the diet was very slowly expanded, only one new food being added in any two weeks' period. A violent flare-up limited to the face occurred one week after beef was added to the diet at the age of 6 months. It promptly subsided when beef was removed from the diet. Minor flare-ups greeted the addition of carrots, applesauce, and oatmeal to the diet; each time the eczema disappeared when the food was discontinued. Her diet, while simple and monotonous, was nutritionally adequate, and her condition at the age of 1 year was in every way satisfactory. Whole cow's milk was given at the age of 18 months. She is still an allergic child, as shown by recurrent hay fever.

## Comment

The stories of these two patients have many points in common, but the handling and the results were very different: the second child was possibly *prevented* from becoming an eczema problem: the first was almost certainly *made* into an eczema problem.

Two cases prove nothing: these cases are presented only to illustrate the typical preliminary history of an eczema problem, and to show the preventive treatment of eczema in action.

## Preventive "Treatment"

This preventive treatment may be summarized as follows:

(1) Inquire into the family history of all newborns, and consider every infant with an allergic family history as a *possible* eczema problem.

(2) Encourage breast feeding whenever possible, especially in allergic families.

(3) Give no artificial formula to any infant under the age of 3 days.

(4) Recognize allergic colic when it occurs and treat it as such; consider every such case as a *probable* eczema problem.

(5) Start no complementary foods in these children under the age of 3 months.

(6) Introduce new foods one at a time, and in small amounts.

(7) Use no mixtures of foods, such as the commercial "mixed" cereals or the absurd multiple compounds of meats, vegetable, and cereals.

(8) Stop the most recently added food if eczema occurs. If it persists, go back to the base diet—milk or

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milk substitute—*alone*. If eczema persists, change the base diet.

The use of this simple system over a ten-year period has had the following result: No severe case of eczema in a practice which includes an average of 8-12 new cases of severe eczema per year among infants *not* cared for from birth. Is this accidental? Perhaps so: but let us try to see if there are any scientific facts to justify the assumption that this method may prevent severe eczema. The entire system is based on two beliefs: (1) That food sensitivity is the original cause of infantile eczema; and (2) that the younger an infant is, the more easily is he sensitized.

### Rationale

First, as to the relationship between food and infantile eczema: My dermatologist friends, who seldom see anything but advanced cases, are often skeptical. On the other hand, the relationship is beautifully easy to demonstrate in early eczema: stop the food and watch the eczema clear; give it again and the eczema recurs.

Why then, is it almost impossible to demonstrate such a relationship in the well-established case? At least three reasons can be given: (a) Food sensitivities are often multiple; (b) When the skin has undergone thickening and inflammation for a long period of time, it also takes a long time for it to become visibly improved by a change in diet; and (c) raw areas in time almost invariably become infected, and the added factors of infection, bacterial sensitization and contact sensitivities may perpetuate the eczema, even though the original causative factor is removed.

Second, why no formula under three days, and no complementary foods under the age of 3 months?

Infants are born allergic, but seldom allergic to any specific food. Food sensitivity is presumed to be acquired by absorption of unchanged protein through the intestinal wall. The larger the dose of unchanged protein, the greater the chance of sensitization.

Experiments have shown that blood plasma given by mouth to an infant in his first day of life will appear in the blood almost as rapidly as though it were given by vein. Measurable amounts go through in the second day; after that time the amounts are too small to measure. While it is unsafe to assume that cow's milk protein behaves exactly like serum protein in the infant's intestine, it seems justified to say that the intestinal wall is more permeable to unchanged protein in the first two days of life than it is later on.

We have indirect evidence of a gradually improving intestinal barrier in the usual history of colic; the majority of cases improve or clear spontaneously between the ages of three and four months. Another piece of indirect evidence is the fact that the foods most commonly demonstrated as causes of eczema are cow's milk and wheat: these two foods are commonly the *earliest* foods fed to infants.

Since there is, then, reason to believe that a child is most easily sensitized in his first days of life, and decreasingly so to the age of three months, why give him protein food under the age of 3 days, when it is unnecessary, or complementary foods under the age of 3 months, when they are unnecessary.

The diet is kept simple in order that flare-ups may be more easily traced to their cause; mixed foods are avoided because they make difficult the identification of which food produces eczema. A return to a base diet during flare-ups makes it possible to determine whether the base food (i.e. milk or its substitute), or one of the complementary foods, is to blame.

### Conclusion

I would like to conclude with some philosophical observations on the modern trends in infant feeding.

It has long been noted that most infants fed exclusively on milk tended to become anemic around the age of 5 or 6 months. Some years ago, with awed caution, a few doctors began to give appropriately smashed up complementary foods before this age, and found to their delight that most babies took them well, and that "milk anemia" could be thereby prevented.

Then the race was on, with the mothers on one side and the doctors on the other, spurring each other on to see who could start the most foods earliest. Since it is modern, and good, they argued, to give solid foods earlier than we used to, then the earlier we give them the more modern, and therefore the better, the feeding system.

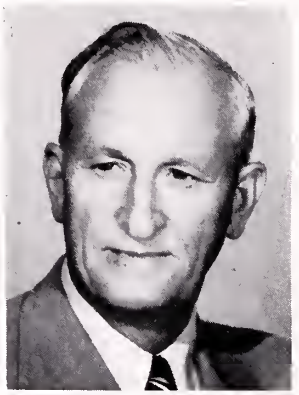
I am afraid we pediatricians have taken a leading role in this pell-mell race. It has been to our advantage to make infant feeding so complicated that only a specialist could comprehend it. Fortunately, the average infant has suffered no harm, as he can digest steak, onions, and mince pie as long as it is first reduced to a mush. But, how about our allergic infants? I think it is high time we stopped to consider whether we are not creating needless eczema problems.

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# SURVEY OF THE FAR EAST COMBAT THEATER

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PERMISSION to appear on the program of the Ninety-eighth Annual Meeting of the Hawaii Medical Association is appreciated particularly because my topic on this occasion does not directly concern a medical or surgical subject. However, if this or any other medical society maintains its proper position, it must make a place in its program for social, economic, political and international discussions, especially those that bear directly or indirectly on the whole welfare of its membership and its responsibility to the public.



DR. PINKERTON

I was commissioned to make a critical survey of medical installations in the Far East zone of military operations and to consult with the medical officers of the armed forces on matters pertaining to oto-ophthalmology and allied services. It was further my duty to render a report to the Surgeons General of my findings, criticisms and recommendations and to speak of those observations to lay groups, medical associations, etc., so that they might also be informed on medical military affairs as I found them.

It is probably just as well that this report to the medical profession of Hawaii is somewhat delayed, since such a report requires much time for proper circulation and evaluation, much correspondence and many conferences before it finally becomes operative. I quote in part from instructions: ". . . where pertinent and constructive criticism is necessary to an honest appraisal by you, it is in the public interest that such criticism not be withheld. Military security should be considered to the extent that information made public could be of value to an enemy or potential enemy."

With the authority just quoted, I shall set forth observations which fall outside "top secret" information and which, after careful screening, are determined to be beyond the limits of military security. Many of my remarks may seem critical but in making them I also offer constructive suggestions in the hope of correcting some procedures.

Read before the ninety-eighth annual meeting of the Hawaii Medical Association, Honolulu, May 13, 1954.

It must first be stated that all of our armed service units are doing an exemplary job in every phase of medical care to our soldiers, providing prompt medical service of the highest quality to every man in the service. Excellent food, the best clothing, the very best fighting equipment, excellent recreational facilities, and personal attention to individual problems have made our fighting and defense units a mighty force, so necessary not only in peace-time but in the active defense of our country in time of war.

Immediately upon arrival in Tokyo I was escorted to the staff officers' hotel and reported immediately to Headquarters where detailed orders were awaiting me. I was to visit every military medical installation of importance in Japan, Korea, the Philippines, Okinawa and Formosa—and at the request of the proper command I visited Hong Kong. In each of these installations I examined many cases in consultation, held clinics with the medical officers, examined the physical features of the unit, lectured from one to two hours to all the medical officers in each command, examined the complete medical and induction records of hundreds of controversial individuals whose problems ranged all the way from war injuries and other legitimate conditions to major congenital defects and those of the "gold-bricking" or "malingering" variety.

Having inspected the 406 Tokyo Central Laboratory, where blood from the United States was received and sorted, it was interesting to follow the distribution of that blood right up to the M.A.S.H. hospitals and to the first-aid stations on the battle line.

From the foregoing you will understand, I am sure, why I was able to arrive at some conclusions regarding certain military and induction procedures which I feel need correction. This will be more interesting to those who have recently served in the armed forces, and should be particularly interesting to those who may see military duty at some future date. Those who have not served should also be interested, if for no other reason than being a taxpayer whose taxes in such large proportions go for defense purposes, pensions, compensations, etc. The terrific cost to the taxpayer of the present apparent laxity in induction technique is staggering, and I shall attempt to show you why this seems to be true.

I believe that every citizen of our country, man or woman, should serve in the armed forces in

some capacity. I am convinced that those who have served are better citizens and have a better understanding of citizenship, loyalty and self-esteem than those who have denied or been denied their patriotic duty. Regulations that make it possible for a reluctant inductee to exaggerate a perfectly transparent or trivial defect for the purpose of evading his patriotic duty must be totally condemned—be that defect a headache history, a tag of hemorrhoids or devout cowardice. Such individuals need the benefits of military duty for their own self respect and the strengthening of their moral fiber much more than the service needs them for the defense of our country.

I believe defects which are not disabling enough to render an individual totally useless in any of the innumerable positions the services have to offer should not be used as escape mechanisms from military duty. I am strongly of the opinion that when inductees are examined for military duty every defect should be recorded on the induction record on the basis of the best physical examination it is possible to provide. Not only should the individual be inducted, but each defect should be carefully recorded and his assignment to duty made on the basis of a complete and thorough physical record. No matter what defect is found, there is a place for him, or her, in the Armed Forces. The reasons will be more obvious as I go further in this report.

From experience in World War I and II and this recent inspection duty, plus many years as consultant at Tripler Army Hospital, I feel that my opinions are of value. On this trip I examined, and was consulted concerning, several hundred individuals, and examined the complete medical and induction records of many of these men and women. Except in rare instances, the majority of these had little or nothing disabling enough to prevent them from carrying on the duties assigned. It was the rule that complaints were based on obvious congenital or pre-induction defects. Resolved not to do the duty assigned them, they gave the universal argument that their defect made it impossible to carry out the assignment. Honestly or dishonestly, they would look you right in the eye when interviewed and state their objections. The examination almost always revealed retinitis pigmentosa, amblyopia exanopsia, defective vision, high myopia, defective hearing, muscular imbalance, nystagmus, obvious exo- or eso-trophia, ptosis, pterygia and a host of other perfectly apparent defects. Of course such persons should never have been sent to the war theater, but the first and greatest felony was committed by those who conducted the induction physical examination in failing to accurately record those defects on the induction record. Certainly these men should have been inducted and put through every phase of military training, boot camp and all the rest, and then assigned to the many duties at training camps which such defectives can easily do, thus releasing those who are fit for forward duty.

If this technique had been followed, precious transportation space would have been saved in sending them forward and, more particularly, precious space would have been saved on planes returning those men to the U. S. when that space should be available for those being returned because of war wounds, termination of service, rotation, or other legitimate reasons.

Many of you are perhaps unaware that all air evacuations from the Korean theater are via Honolulu and those, plus most evacuations by ship, constituted approximately 98% of our returnees. Studies have been made to warrant the statement "far too many of these evacuees were those who had done no duty in Korea but spent from a few weeks to a few months going from center to center in the forward area, from one specialist to another seeking one principal objective—that of a transfer back home because of a partially blind eye which they knowingly have always had, or any one of many other congenital defects which they have always been aware of." Yet, when we examine the induction record of such individuals it is silent or grossly inaccurate.

The slap-dash technique of examining the ordinary inductee by asking him, "can you see this, can you hear this?" and then recording the findings as normal is probably the greatest omission. I found this to be true in hundreds of the records I examined.

Now, why is it so important that these defects be recorded accurately? The inductee is examined and his record says his vision is 20/20 with each eye and his hearing normal in each ear. He gets his basic training, is outfitted and sent overseas at a cost of more than $10,000. He arrives at his combat zone destination and decides he doesn't like his assignment, and in this I may agree, for there are no desirable assignments in Korea or for that matter in any other combat theater; but he is there.

Now, how to get out? How to get transferred? He knows he has defective vision in one or both eyes; he knows he has night blindness; he knows that one or both ears are defective. For the first time in his life he becomes concerned because one eye is crossed or one lid droops, so he immediately centers his attention upon his well known (to himself) defect and insists that this defect which he has always had and which never caused him

any trouble, now suddenly is so troublesome that he honestly, or more often dishonestly, decides it renders him unfit to perform any assignment he is given.

When such an individual is screened out of actual forward combat duty, a chain reaction is started so effectively that he decides he cannot even do K.P. duty. He is sent from center to center to be examined over and over again by specialist after specialist, including the psychologist and the psychiatrist. This takes the precious time of good medical officers whose services are needed for the care of the legitimate patient. Mind you, all of this time the inductee is occupying a precious bed in a crowded unit. Finally, after the gamut of examination after examination, he accomplishes his purpose and is transferred back to the States, occupying that precious space so needed by a wounded man or an otherwise legitimate transfer.

In a period of four months in 1952, 500 consecutive air evacuee eye cases were examined at Tripler Army Hospital. Of this number 27% were errors of induction of the evacuees. Of this group, 13% should not have been returned to the Mainland, but should have been forced to do their duty. The others were obviously unfit for duty, with such conditions as congenital cataracts, uncorrectible visual defects and other serious eye conditions, and should have been returned.

In another group of 2,457 consecutive air evacuation eye cases, 1,568 were due to actual battle injuries. The Army had 1,372, the Marines 168, the Navy 15 and the Air Force 13.

In the whole group there were 889 defectives which we might classify as follows:

| | |
|---|---|
| Congenital defects | 132 |
| Old injuries, etc | 121 |
| Old diseases (healed) | 108 |
| | 361 |

and major refractive errors:

| | |
|---|---|
| Exo- and eso-trophia | 107 |
| High myopia, high hyperopia, astigmatism | 52 |
| Pure eye malingerers | 6 |
| | 165 |

These two groups of 526, exactly 20% of the total of 2,457, should never have been sent to the combat zone.

The remaining 363 of the total comprised a long list of conditions that were difficult to classify and of no value in this report.

Now you may think this is the end, but it isn't by any means. This individual (one of the 526) appears again when he comes up for discharge. He claims that his defective vision or hearing or what-have-you resulted from his military duty, or was made worse or exaggerated by such duty. He may unguardedly admit that his defect had been present before his military service, but he finds that since he entered the service he is unable to do the kind of work he was doing prior to induction. The chain of events then runs something like this: he is inducted into the service, given a cursory examination, and no congenital defects are recorded; he receives his training and without further screening is sent overseas; he does little or no duty, spends from a few weeks to three months going from unit to unit; finally he is transferred back to the Mainland. He comes up for final discharge, or he may be discharged on the basis of his physical unfitness; he knows that the record is "silent" on his pre-induction defects; he receives a compensation award in amounts varying from $25.00 to $100.00 per month. Is this the end? In too many cases it is not. A few months after his discharge he writes a letter to the Board claiming increased disability and through the Veterans Administration he is sent to a physician for another examination and report out of which he hopes to get his compensation increased. He says, "I was all right before my military service, the record shows that. Now, I cannot do the same kind of work I did prior to my service,"—so his compensation may be increased for a defect that he had always had and which was in no way increased or contributed to by military duty.

Now, let me review what else may happen. For example, let us consider the inductee with a pterygium, a crossed eye or a ptosis of the upper lid. These defects were present all his life; they never bothered him before. He is examined but the record is silent. He is sent overseas; he doesn't like his duty; he doesn't like any part of Korea; he reports at sick call complaining of redness of the eye, pain, double vision, headache or any other complaint that comes to his mind. The medical officer sees the defect; he is "taken in" by the patient and his complaint. The patient is admitted to the sick unit in some small installation designed only for short term, acute cases of injury or illness pending a transfer back to a base hospital. Is he transferred? Too often, No! The knife-happy or eager young surgeon who may have had some experience with such cases or no experience at all, wants to keep his hand in and decides he will operate. Here is another major error to compound the first. The instant that such a case is operated upon the government admits or assumes liability. Such cases are not duty-connected, are not emergencies and should never be touched surgically while the man is in the service except in rare instances, and only when the patient is sent back to

a base hospital where his case may have the careful consideration of one highly skilled and where a Board can sit in review to make decisions that may obligate the government for untold millions of dollars.

I have examined many cases of men who have returned from Korea. Far too many now receiving disability compensation should not be receiving any compensation at all. Why do I know this? I have practiced medicine in Hawaii for more than 37 years, and kept a careful record of every case I have examined and treated. When a discharged veteran comes to my attention, I look in my files and frequently find that he has been examined by me many times during his early years. My records often show that the patient had defective vision due to a congenital condition, a ptosis, or a chronic running ear with resultant reduced hearing. I have found patients who hear even better today after active military duty than is indicated in the several audiograms taken from childhood to manhood—yet they are getting $87.50 per month for a defect which my records prove was present long before their induction.

My plea is this. Many young men in medicine will soon be in the military service and have occasion to conduct pre-induction examinations. I beseech you to look seriously upon your responsibility in recording all data of such an examination on the induction record. If that is done, much will be accomplished, not only in saving unestimated millions of the tax dollars but, more than that, in discouraging the inductee from becoming literally dishonest in trying to obtain a pension or compensation for a condition which is not the responsibility of the government. Also, if you find yourself in the position of the Camp or Unit Surgeon, think many times before you obligate the government by laying your knife on a pre-induction condition except in dire emergency, and then only after a consultation with one in higher authority who should sign his approval on the service record.

Our induction system, our induction boards and our physicians who do the induction examinations are responsible for the errors I have outlined above. Enlightenment of the medical profession and the public will help to correct these careless procedures.

The greatest responsibility must be charged against the various services for continuing to operate recruitment or induction centers in the same archaic style of a century ago. The cost of a careful, critical, properly recorded pre-induction examination represents pennies as compared to millions of compensation dollars.

## Conclusions

In conclusion, the following observations are offered:

1. Modify downward physical requirements for all the armed service units. (There is an excellent place for the lame, the halt and the blind somewhere in the military services, if the military authorities use average intelligence in assignments and if and when they finally become realistic and practical enough to realize that the services can properly place any man or woman according to his intelligence and physical capabilities.

2. Complete the best physical examination possible on each individual, man or woman, and record everything in the service record at the time of induction,—then induct him, or her.

3. Profile every inductee once, carefully and thoroughly, and do not repeat it under two years unless special requirements or changed conditions mandate it.

4. Use and utilize medical men possessed with intelligence and special skills in the areas where they can give the best service which their background and training indicates.

5. Never operate upon a service man or woman for any pre-induction condition, except upon approval of a board of medically or surgically qualified men.

6. All preventative and medical research programs should be completely under those trained in the medical field and never under the administration of non-medical personnel. The medical supply departments should be under and controlled by medically trained men, bona-fide doctors of medicine.

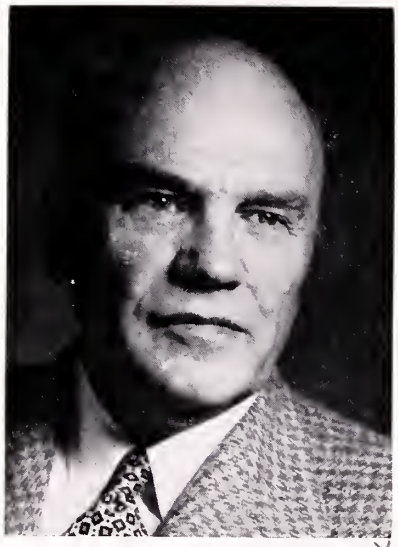
7. The supervision of all medical men of the armed forces, on professional problems, should be under highly skilled medical men and never under non-medical personnel.

8. Twenty million—and this is increased by one million per year—veterans are costing our Nation in taxes untold billions of dollars annually, one large expenditure being for pension payments for conditions neither caused by nor contributed to by service in the armed forces. These phony compensation pensions, so easily obtained, are making a nation of dishonest and grafting veterans.

9. The French Army examines the eyegrounds of horses with an ophthalmoscope before purchasing them for military purposes. Our military authorities might go a step further when performing induction physical examinations on our men and women of the armed services.

---

Young Hotel Building.



NILS P. LARSEN, M.D.

# *The President's Page*

This page is a good institution. It allows the President an opportunity to tell the membership at what he is shooting. It gives you a chance to shoot him full of holes if you disagree. If he doesn't attain his "pronouncement" you will know he has failed and can call him on it.

However, a leader can only indicate a way. If the majority do not follow, he has failed, somewhere.

The year ahead is full of real problems. But if "happiness consists in overcoming obstacles," let us attain a full measure of happiness.

A projected plan for Hawaiian Health and Hospital Care will, I hope, gain the support of the vast majority of our membership. Study it carefully before you sign, pass it up, or explode. If the majority do not accept it, the plan will fail. By our failure we will invite the mainland group who claim "too many die too soon" because of our lack of service. By united effort we can give better service than any projected mainland plan.

I hope soon we can amicably agree on a solution of the "free choice of physician" problem. The Legislature will meet in February. There are many health necessities that will need our support.

How can we improve our "preventive medicine"? Philadelphia has shown how a hospital (Lankenau) can help greatly in community health education. Each hospital should accept the challenge that its job is not only in curing the patient of the illness which brought on the admission, but also in teaching the patient and the family how to prevent future admissions.

Each hospital must also foster the spirit of research. Status quo is stagnation.

Physicians must remain devoted to the task of doing themselves out of a job by teaching people how to stay well. Let us not be in a class with those who refused to give up the horse and buggy because it had been used so long they knew it would continue. Who could have dreamed then of a day when there would be a car for every three persons? The stubborn human brain clings to and loves an old pair of shoes. As physicians we must remain alert to the new, especially if the new means better service for the sick.

*Nils P. Larsen*

Hawaii
MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE
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## [EDITORIALS]

## Report of the House Bill No. 692 Committee

"House Bill 692"—an attempt to transfer free choice of physician from the employer to the workman in Workmen's Compensation cases—died by pocket veto in the last session of the Territorial Legislature. The Journal approved this veto, on the ground that the bill was so extensively and inadequately "patched up" at the end of the session that it did not solve the many complex problems involved, and on the ground that some features of it were unworkable.

Governor King appointed a committee, representing all interested parties, to study the problem; and that committee has concluded its deliberations and come up with a carefully considered, detailed series of recommendations. We urge every interested physician to study them carefully, and be prepared to either abide by them, or offer specific recommendations to the Hawaii Medical Association for modifying them.

June 22, 1954

Board of Governors
Honolulu County Medical Society

Gentlemen:

I have just perused the excellent and extensive study made by the Governor's Study Committee on House Bill 692 concerning Workmen's Compensation cases. I agree 100 percent with Governor King's statement:

> "It is my judgment that this committee report is sound and workable, and I hope that the proposals made therein will, in good faith, be given a fair trial by all parties."

If anything is to work there must be a spirit of good will among all participating units. Without good will the most perfect document would fail. I would like to compliment the men who made the study for having done an excellent job, and I believe that the doctors will be more than willing to do their part in making a sincere united effort to make the Committee's recommendation a success.

NILS P. LARSEN, M.D.
*President*

### The Report

The committee recommends that an employee who suffers an injury covered by any workmen's compensation law be treated by a physician of his own choosing, subject, however, to the limitations set forth below.

The limitations upon the choice of a physician in workmen's compensation cases are:

(1) Any physician duly licensed to practice medicine or surgery in the Territory of Hawaii shall be eligible to care for injured employees as the primary physician.

(2) The employee's choice of a primary physician shall be limited to a physician practicing within the community in which the employee is injured or in which he resides.

(3) If an employee is so severely injured as to be incapacitated from making a choice, or if the employee does not make such choice after being informed of his right to do so, the employer shall select the physician.

(4) The employer or insurance carrier shall have the right at all times to have the injured employee examined by a consultant or consultants of its choosing. All records, x-rays, etc. pertaining to the injured employee shall be available for inspection by the employer or insurance carrier or its consultant or consultants. The primary physician chosen by the injured employee shall be informed of any findings and recommendations made by any such consultant.

(5) If a serious injury is likely to result in permanent deformity, disability or disfigurement, the injured employee shall be entitled to a consulting physician. The consulting physician shall be chosen by

the employee unless he is incapacitated from making such choice. In that event, the primary physician shall choose a consultant from the Master List. However, the choice of the consultant by the injured employee or the primary physician shall be first approved by the employer or the insurance carrier. Such advance approval shall not be required in any case in which delay in obtaining the services of a consultant would be prejudicial to the treatment of the injured employee.

(6) Whenever the injured employee is dissatisfied with the care furnished by a primary physician, he may choose another physician. Whenever he is dissatisfied with the care furnished by a consultant, he may choose another consultant. However, this privilege of selecting another primary physician or consultant or both may be exercised only once by the injured employee.

(7) Whenever the employer or insurance carrier is dissatisfied with the primary physician or consultant selected by the injured employee, the employer or insurance carrier shall have the right to require the injured employee to select another primary physician or consultant. Whenever this privilege is exercised, the employer or insurance carrier shall inform the physicians of the reasons therefor.

(8) Before any secondary or elective procedures are undertaken (such as repair of hernia or nucleus pulposus, bone grafts, etc.) the physician in charge of the injured employee shall notify the employer or the insurance carrier of the need for such secondary or elective procedures and secure authorization to proceed with the contemplated treatment.

The Committee recommends that the Hawaii Medical Association be requested to make available to all interested parties a list of the names of physicians who are qualified in each specialty of the medical profession. The Committee believes that the preparation and maintenance by the Association of a Master List of consulting physicians will implement the recommended program and be an invaluable aid in obtaining for injured employees the best possible medical care.

The medical members of the Committee recommend that any Master List of consulting physicians prepared and maintained by the Hawaii Medical Association be made up of physicians who have been qualified in each specialty by the respective American Specialty Board or who have demonstrated ability, skill and judgment in one of the various specialties for a period of at least five years. Any physician who has passed the first portion of his specialty board examinations may present evidence of that fact to the Hawaii Medical Association. Thereupon, the Association shall place his name on the Master List as a "temporary appointment." Such "temporary appointment" shall become a "permanent appointment" upon his passing the final part of his board examinations. Failure to pass the final part of his board examination within five years of passing the first part shall be cause for removal of his name from the Master List.

April 7, 1954

The Honorable Samuel Wilder King
Governor of Hawaii

Dear Governor King:

The Governor's Advisory Committee, created by you on June 12, 1953, to make a study of the problems of selection of physician in the treatment of injuries or sickness coming within the purview of the Territory's Workmen's Compensation Laws, herewith submits its report.

This report is a result of many hours of consultation by the members of this committee who represent industry, labor, insurance and the medical profession. In addition, this committee had the benefit of advice and opinion from authorities in the fields of workmen's compensation and industrial medicine in the United States and Canada. This material included observations and reports obtained from the leaders in labor, Federal, State and Dominion governments, spokesmen for the medical profession and the general insurance industry.

The primary objective of the medical provisions of the Workmen's Compensation Law is to provide the injured employee with the best medical care obtainable so that he may return to gainful employment as soon as possible. It is the opinion of this committee that the recommended voluntary plan allowing the injured employee to choose his physician under the workmen's compensation laws holds the most promise for a fair and effective solution.

Having reached this conclusion your committee recommends that adequate time be allowed for the working out of the recommended program and an evaluation of the results obtained. We believe that this program will result in the maintenance of the highest type of medical care, while at the same time providing for individual choice of physician within certain necessary rules of procedure.

The committee recommends that in any workmen's compensation case the declared policy be that the injured employee may choose his physician in accordance with the recommended program.

Signed by:

William S. Ito, M.D.
Steele F. Stewart, M.D. (with reservations)
B. Allen Richardson, M.D.
Carl J. Guntert
Tomoo Tsuchiyama
Arthur J. Latta
Harry G. Albright
S. K. Chillingworth
Robert R. Trent
W. T. Yoshimoto
D. K. Garrison

The Committee recognizes that in general, plantations have, pursuant to practices of long standing, provided extensive medical care for employees and their families as well as medical care for employees in industrial accident cases. The Committee believes that the situation of such plantations differs materially from those employers who do not provide such medical care in both industrial and non-industrial cases. Accordingly, the Committee believes that the recommended program is not applicable to such plantations and that they should not be requested to participate.

In concluding, the Committee desires to emphasize that this Report should not be deemed a recommendation or a suggestion that any employee, employer or insurance carrier should relinquish any right under any applicable workmen's compensation law, except that employers (exclusive of the above-mentioned plantations) and insurance carriers should permit injured employees to choose their own physicians subject to the limitations specified.

## The Kaiser Plan

Mr. Henry J. Kaiser's recent efforts to lease beds from Kapiolani Maternity and Kauikeolani Children's Hospitals in Honolulu, preparatory to establishing here a medical group prepayment plan of the Permanente type, were considered by the House of Delegates of the Hawaii Medical Association at their annual meeting last May.

The delegates contented themselves with a reaffirmation of their confidence in, and support of, the Hawaii Medical Service Association—a prepayment plan embodying, unlike the Permanente Plan, free choice of physician and hospital, and fee for service. There was no official expression of opposition to Mr. Kaiser's proposal—merely a clear implication that the Association saw no need for it. This action was unanimously approved by the Honolulu County Medical Society on June 4.

The American Medical Association has long remained non-committal toward the Permanente type of prepayment plan. The arrangement is not officially regarded as unethical, except by the Los Angeles County Medical Society, who outlawed it in 1953. It has been unpopular with other physicians, however, chiefly because it restricts the patient's choice of physician to members of the group for as much as a year in advance. If they become dissatisfied with their doctor and feel impelled to go elsewhere, they must pay for it themselves, and sacrifice their prepaid premiums.

Certain advantages are claimed for the Permanente Plan. It is relatively free of restrictions as to either pre-existing diseases, or particular chronic disorders, or upper limits on total amounts of service. An illness does not cost the Plan more money—it costs the doctors more work, and the patient a little more money: a dollar a visit, plus cost of drugs except in the hospital. Diagnostic services, preventive medicine, and prolonged hospital stays (up to 111 days) are better covered than in most prepayment plans.

The combination of a "captive" patient-population, plus a fixed income (either salary, or a relatively fixed share of income), tends toward certain abuses. Patients are apt to request unnecessary services, and doctors are apt to render those services as hurriedly as possible. In such a situation, efficiency pays off; the warm, personal physician-patient relationship does not.

The Permanente Plan also seems relatively inexpensive, as prepayment plan premiums go. It is not so inexpensive if one considers that (1) nonuse averages 40 per cent—either because of nonillness, or preference for a doctor outside the Plan; (2) a fee of $1 is charged for each office visit; (3) drugs (except in the hospital) are paid for separately; and (4) obstetrical deliveries are $60 extra for the subscriber, and $95 for dependents. Medical care of good quality is an expensive commodity any way you look at it, and there is no magic way of selling an expensive product cheaply without going broke in the process.

Mr. Kaiser spoke recently, before the National Press Club, of what the average American wanted in the way of medical care. He didn't mention one thing on which most people set a pretty high value: being able to get the doctor they have the most confidence in at the time when they want him. It is a curious fact that the average American wants to change doctors from time to time and for particular kinds of illness. Confidence in the doctor is still an important, even an essential, ingredient of most prescriptions—and the patient knows it. Not every patient will be able to tolerate the restriction on free exercise of choice, in this respect, that the Permanente Plan entails.

Many patients also have definite preferences in regard to hospitals; and here too, in the Permanente Plan, Hobson's choice—the Plan's hospital or nothing—is offered. Moreover, Honolulu's hospitals can ill afford to lose patients to another hospital.

There is nothing to prevent the establishment of a Permanente Plan in Honolulu, though the need for it seems doubtful, in a community so well covered with voluntary prepayment plans of both service and indemnity type. To the extent that such a restrictive arrangement—private enterprise

though it is—interferes with existing physician-patient relationships and paves the way for future regimentation of medical practice, we are against it. It is evident that the doctors in this community would like to go on solving their own medical care problems in their own way.

## Sixth Congress of the Pan-Pacific Surgical Association

Plans for the Sixth Congress of the Pan-Pacific Surgical Association which will be held in Honolulu, October 7-18, 1954, are rapidly nearing completion, and all indications point to the most outstanding Congress in the history of the Association.

Delegates from many of the Pacific area countries have made definite reservations to attend the Congress. Countries already represented include Alaska, Canada, Argentina, Australia, New Zealand, Panama, Hong Kong, Puerto Rico, Mexico, the Philippines, Japan, Venezuela, Korea and, of course, the U.S.A. It is inspiring to note that many of the delegates have had to overcome overwhelming obstacles in order to attend the Congress, especially those from such war torn countries as Korea and those from dollar restricted countries such as New Zealand.

Requirements for a place on the scientific program have been kept at a very high level. Assistance of the officers of the various surgical specialty groups of Honolulu has resulted in the development of the most distinguished surgical program ever to be presented in Hawaii.

The preliminary program, consisting of about 150 papers, has already been prepared for the membership and the program participants. Because the program is so large, it has been divided into ten sections: general surgery, cardio-vascular surgery, thoracic surgery, proctology, obstetrics and gynecology, orthopedic surgery, urology, neuro-surgery, ophthalmology, and otolaryngology. All sections will meet in the Waikiki area and the program will include the ever-popular breakfast clinics to be followed by formal sessions which will last until noon daily. The scientific program will be restricted to forenoons only.

Since one of the basic aims of the Association is to ". . . further the principles of hospital administration and standardization," the Association will again incorporate the Hospital Institute in the formal program. This will consist of four forenoons devoted to papers, seminars and discussion groups held simultaneously with the surgical sections of the program.

As in the past, an open meeting for the public will again be scheduled, and popular controversial subjects will be featured. For instance, Michael DeBakey will speak on "The Relation of Smoking to Cancer of the Lungs" and Harris B. Shumacker, Jr. on "What Does Surgery Have to Offer to the Cardiac Patient?"

The social program has been developed with the assistance of several Ladies' Committees, the members handling individual phases of the social events. A welcoming cocktail party will be held at the onset of the Congress; there will be a Brunch Fashion Show staged exclusively for the wives of the delegates; a golf tournament with unusual prizes will be offered; the Navy has agreed to schedule extra sailings of their motor launches for the highly popular Pearl Harbor Tours; a jet air show has been developed by the Plantation Physicians for the delegates at the Congress; Governor King is planning a reception for the surgeons; and the climactic closing luau is again being planned in elaborate detail.

One of the most outstanding features of the entire Congress will be the pageant accompanying the dedication of the new surgical wing at The Queen's Hospital. An original pageant depicting "The Evolution of Surgery in the Pacific" will be shown for the first time. A large cast will take part in this magnificent event, which will portray the contributions made to surgery by the various racial groups as they arrived in Hawaii. Authentic details in the form of the costumes, music, dances, songs, and instruments, etc. will be shown. This event will be so colorful as to attract widespread interest among editors of large mainland publications.

Membership in the Association has only been available since incorporation under the laws of the Territory in 1951. Already there are over four hundred members, and of these, more than one hundred are doctors from the Hawaiian Islands. Membership has been divided into three categories; Regular Members, Associate Members, and Organizational Members. As interest in the Association has become more and more keen, applications for membership are received almost daily. Since the registration fee will be in the neighborhood of that charged at the Fifth Congress, it is of definite advantage for local doctors to hold a membership and take an active part in an Association that has steadily grown from a modest beginning in 1928, to a stature of world recognition today.

F. J. PINKERTON, M.D.

# Umi Makahiki I Hala*

## ALOHA, MRS. BOLLES!

Mrs. Elizabeth Bolles, real founder and Managing Editor of the HAWAII MEDICAL JOURNAL, founder and editor of its predecessor the *Bulletin,* secretary of the Honolulu County Medical Society and the Hawaii Territorial Medical Association since 1936 and their full time executive secretary since 1938, and right hand woman for every Society and Association officer throughout that period, is leaving us as this issue goes to press. We are on our own.

It would take a page merely to enumerate the services, over and above the specific ones for which she was employed and remunerated, that Mrs. Bolles has rendered to the physicians of Hawaii during her term of employment. To mention a few of the more important ones: it is largely through her efforts that the records and archives of the Territorial organization are in recognizable condition and available for inspection; that we have an orderly collection of books and journals in the Charles Adams Library; that the medical society's relations with related organizations in the community are so direct and satisfactory; and, as already mentioned, that the Territory has its own medical publication.

Her work here will be taken over piecemeal by a librarian, Mrs. Ethel Hill, and two stenographers, Miss Pat Hayward for the Honolulu County Medical Society, and Mrs. J. Gardner Bennett for the Territorial Medical Association and the HAWAII MEDICAL JOURNAL. Miss Ethel Tsutsui will continue to operate the bookselling service in the Mabel Smyth Building as heretofore, as Mrs. Bolles' representative.

* Ten years ago. From Volume 3, Number 6, July-August, 1944.

## ANNIVERSARY CONGRATULATIONS TO DR. WALKER

The competent sanatorium care available for tuberculosis in the Territory of Hawaii is in large measure a result of the efforts of Dr. Hastings H. Walker, Director of Leahi Hospital for nearly fifteen years. The tuberculosis hospitals on Hawaii and Kauai are under the direction of former members of Dr. Walker's staff.

## CIVILIAN HOSPITAL NEEDS

*City-County Hospital:* Several persons have expressed the opinion that Honolulu should have its own city-county hospital, on a grand scale, to care for all the indigent, aged and others. Many years of experience in such institutions, and study of those in Los Angeles, New Orleans, Jersey City, and others, leave no doubt that Honolulu is indeed fortunate not to be carrying such a burden.

Indigent patients are now cared for in the city's voluntary hospitals at a very reasonable rate, and they receive the very best of care. This cost only $70,000 in 1943, about what it might cost to prepare the plans for the magnificent institution that has been recommended. As long as this service for the sick and poor can be rendered at so small a cost, it would be difficult to justify the construction and development of a new institution.

LUCIUS W. JOHNSON, CAPTAIN, MC, U.S.N.
(*First part of three*)

# This is What's New!

Aldous Huxley takes 0.4 grams of **mescalin,** a pure alkaloid extracted from a desert cactus, and is so moved by its remarkable effect that he is compelled to write a whole book about his reactions during the next few hours. He found that his ability to remember and think was not impaired but that perception, especially for color, was greatly increased, while interest in space-time relationships was greatly diminished. His vivid descriptions are such that alcohol, by comparison, seems almost like weak tea. After reading this short book, the scientific curiosity of one of our colleagues was roused to the point where he repeated the experiment on himself. He was able to describe the effect in one sentence, "Technicolored nightmares with a mescalin hangover." *The Doors of Perception,* Harper and Brothers, 1954.

' ' '

**Gastric Ulcers and What to do with Them**

J. E. Strode in the *J.A.M.A.*, May 15, 1954, answers an earlier editorial advocating trial of medical management in certain **gastric ulcers** with a sharp rebuttal. He advocates **subtotal gastrectomy** as soon as the diagnosis of an ulcer has been established.

Gott, Shapiro and Kelty in the *New England Journal of Medicine*, March 25, 1954, review 138 patients with **gastric ulcers** seen over a five year period. Their conclusions: Trial on **medical management** unless (1) the x-ray suggests cancer, (2) the ulcer is located in the greater curvature, (3) there is histamine achlorhydria, or (4) the patient is over 50.

' ' '

Kroxatto and Lanari of Argentina investigate a problem that has perplexed physicians since the time of Laennec: the **pathogenesis of bronchiectasis.** By ligation of the left bronchus in dogs, they were able to produce bronchiectasis and conclude that it is probable that all bronchiectasis, acquired, primary or secondary, is caused by a **bronchial obstruction.** The question still remains, however; where is the obstruction in many cases of human bronchiectasis? *The Journal of Thoracic Surgery,* 27:514 (May) 1954.

J. MacDonald in *Surgery, Gynecology and Obstetrics,* February, 1954, develops the argument that **biological predeterminism** rather than surgical treatment is the most important factor. He does not believe that earlier diagnoses will significantly increase curability. He does, however, believe that the only really early treatment is gastric resection for a gastric ulcer which may become a carcinoma.

' ' '

Turner and Landsbury found significant **lowering of diastolic pressure** in 320 patients with rheumatoid arthritis. They found it constantly enough to be of value in differential diagnosis of various types of arthritis. They suggest that some disturbance in the **hypothalamus** may be responsible for the rheumatoid arthritis as well as other collagen diseases and the hypotension. *The American Journal of the Medical Sciences,* 227: 503 (May) 1954.

' ' '

**Nitrogen mustard** and **tri-ethylene melamine** (TEM), both potent cytotoxic drugs, have been used in patients with **systemic lupus erythematosus** with renal lesions. Out of 20 patients so treated, one died of aplastic anemia following TEM. The patients responding the best were those with the nephrotic syndrome treated with I.V. nitrogen mustard. *A.M.A. Archives of Internal Medicine,* 93:667 (May) 1954.

' ' '

From what area do **human sperm** get their energy? By fracturing sperm with low temperature, R. L. Brown found that the main **energy area** for locomotion was in the **mid-piece.** Apparently the middle piece contains mitochondria with essential respiratory enzymes which act upon available substrate to produce energy. *The Journal of Urology,* 71:503 (April) 1954.

' ' '

J. H. Johnston, Jr. joins the increasing number of surgeons advocating **aspiration** of **breast cysts** as a diagnostic and therapeutic procedure in lieu of routine excisional biopsy. The cysts are aspirated by a needle and the cells in the cyst fluid studied by Papanicolaou's technique. Only those

cysts which contain suspicious cells, bloody fluid or a recurrence after two aspirations are excised. This does not contradict the rule, however, that all solid masses in the breasts should be excised for microscopic study. *Annals of Surgery,* 139:635 (May) 1954.

* * *

Harry Kessler of the Veterans Administration Central Office outlines the VA's experience in the care of over 3,000 **paraplegics,** including quadriplegics, since the end of World War II. He points out that, although the complex disability of traumatic paraplegia requires the services of specialists in the fields of neurology, neurosurgery, plastic surgery, internal medicine, urology, psychiatry and physical medicine, it is essential that **one physician be the patient's physician** with the responsibility of integrating the entire team. He also indicates that much careful planning in regard to rehabilitation while the patient is in the hospital goes for naught because of **lack of follow through** in the rehabilitation program when the patient is discharged from the hospital. *Annals of Internal Medicine,* 40:905 (May) 1954.

FRED I. GILBERT, JR., M.D.

# Correspondence

To the Editor:

The Board of Trustees of the Blood Bank of Hawaii herewith submits for your readers the Income and Expense Statement, and a chart showing the number of donors, and blood and blood products used, during the six months period ended March 31, 1954.

A letter dated December 15, 1953 was sent to all physicians in the Territory informing them of an increase in the service charge of $1.00 per pint of blood or plasma used, effective February 1, 1954. The reason for the increase was due to an operating deficit of $5,253.91 for the fiscal year ended September 30, 1954.

The Trustees are happy to report that improvement has been made during the six months period ended March 31, 1954, showing a deficit of $107.52.

In view of this improvement, and the fact that no major expenditures are anticipated in the near future, the bank should be able to meet expenses out of income. Beginning the year 1955, when our Note to Queen's Hospital for the bank's share of the new building, calling for payments of $500.00 monthly plus interest, is paid, the financial picture should look much brighter.

The average monthly incidence of transfusion reactions reported by hospitals to the blood bank during the period covered was .335% major pyrogenic; .383% minor pyrogenic; 1.323% allergic; and .08% miscellaneous. All reactions were investigated by our laboratory for any evidences of incompatibilities.

The Trustees wish to express deep gratitude to the Medical Profession for your excellent cooperation. In spite of the most complete facilities and trained personnel, we could not meet the blood needs of your patients without your help in explaining our program and stressing the importance of replacing blood used. More than 95% of the blood used in the Territory is replaced by friends and families of the patients.

F. J. PINKERTON, M.D.
*President and Director*

June 2, 1954

**BLOOD BANK OF HAWAII**

**Income and Expenses for Six Months Ended March 31, 1954**

| | | |
|---|---|---|
| *Operating Income:* | | |
| Service Charges | $48,900.47 | |
| Blood Replacements | 12,837.15 | |
| Credit Received for Gamma Globulin Plasma | 8,640.00 | |
| Laboratory Fees | 2,793.50 | |
| Tripler Army Hospital (service charges, supplies and laboratory fees) | 20,672.00 | |
| Other Income | 1,896.78 | |
| TOTAL | | $95,739.90 |
| *Operating Expenses:* | | |
| Salaries | $55,762.20 | |
| Field Operations—Mobile Trips | 3,759.05 | |
| Supplies, for Laboratory and Donor Room | 18,723.68 | |
| Utilities | 3,641.48 | |
| Other Expenses (Insurance, Canteen, Postage, Office Supplies, Interest, etc.) | 12,101.60 | |
| TOTAL | | 93,988.01 |
| *Excess Operating Receipts over Expenses* | | $ 1,751.89 |
| *Non-operating Receipts:* | | |
| Donations | | 710.50 |
| | | $ 2,462.39 |
| *Non-operating Expenses:* | | |
| Depreciation | $ 1,177.75 | |
| Travel Expenses | 1,392.16 | 2,569.91 |
| *Deficiency of Operating Expenses over Operating Receipts* | | $ 107.52 |

**Donors, Blood and Blood Products Used for Six Months Ended March 31, 1954**

| | |
|---|---|
| Donors | 10,050 |
| Rejects | 1,921 |
| Donors Bled | 8,129 |
| Whole Blood and Red Cell Transfusions | 6,273 |
| Plasma and Other Sera | 254 |
| | 6,527 |
| Usage by Civilians | 5,336 |
| Usage by Military | 1,191 |

*Blue Shield Plan*
*for Hawaii®*

# HMSA—Its Place in the Community

## Federal Legislation and Medical Plans

At a meeting of the Honolulu Rotary Club on Tuesday, June 8, 1954, Mr. J. R. Veltmann, General Manager of the Hawaii Medical Service Association, spoke on "Federal Legislation and Medical Plans."

Mr. Veltmann reviewed legislation currently before Congress and pointed out the dangerously aggressive purposes of two bills which foster Government intervention in the private loan business and accident and health insurance business. The underlying intent and resultant effects of such bills has been aptly analyzed in "Challenge to Socialism" which is published semi-monthly by the Shearon Legislative Service in Washington, D.C.

Both bills, H.R. 7700 and H.R. 8356, according to "Challenge to Socialism" would eventually permit the Government to control private enterprise and lead to Federal subsidy of business which is the first step to total socialism.

H.R. 7700 would add a new title to the Public Health Service Act and would provide mortgage insurance for facilities used by voluntary prepayment health plans. The bill is put forth as a hedge against socialized medicine and there is the usual disarming and meaningless assurance that "Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any medical facility or group practice prepayment health service plan . . ."

The bill, in brief, authorizes the Surgeon-General to insure mortgages provided that the mortgage does not exceed $5 million, does not exceed 90% of the Surgeon-General's appraised value, is repayable within 40 years and does not bear interest exceeding 6% or in special areas 6½%. H.R. 7700 is long and complicated, but is clearly designed to enable cooperatives, industrialists and other lay groups to set up group clinics and hospitals all over the land, and such groups could eventually become the nucleus of facilities for the Federal Government to institute *national compulsory Social Security medicine.* In addition, it is to assist existing plans such as Kaiser Health Centers and Hospitals and the HIP Plan in New York. Many people have testified at the committee hearings including Mr. Kaiser who wholeheartedly endorsed it—Miss Shearon reports that this is only natural as Mr. Kaiser helped draft the bill. Mr. Kaiser in his testimony made a great issue of the difficulty he and his foundation members had had in financing their hospitals and health centers. If the facilities were financially sound and not in need of subsidy, why would private lending institutions refuse to lend money? If they were not sound, if the percentage of loan sought to total value was higher than private institutions could approve and if the loan period desired was longer than that accepted by private institutions, then would the Federal Government be justified in pursuing a course in direct competition with private lending organizations and require the lending institutions to pay premium charges up to 1½% of the outstanding obligation for the privilege of obtaining Government insurance of their mortgage?

The companion bill, H.R. 8356, is defined as a bill to improve the public health by encouraging more extensive use of the voluntary prepayment method in the provision of personal health services. More concisely, that means it is the purpose of the Government to reinsure prepaid medical plans so that they will offer greater benefits and experiment in areas heretofore considered uninsurable. It was originally designed to provide medical care for the aged, the chronically ill, and those in the low-income bracket who in the past have been unable to afford health insurance. Factually, it is absolutely impossible for the bill

as written to furnish any more care for the unfortunates than they are now receiving through State care. But it does permit the government to enter the health insurance business when there is no need for it. Right now, if it is possible for insurance carriers to offer more coverage, they are doing so and making tremendous strides on their own in offering experimental benefits as actuarial assurance permits. Why should they (just as the lending institutions) foolishly offer benefits beyond actuarial safety, turn to the Federal Government for reinsurance of only 75% of the induced loss and on top of that, pay a premium charge for the privilege? This bill even neglects any mention of the amount of premium charge the carrier would be required to pay.

About this bill, "Challenge to Socialism" says that:—

(1) Commercial health insurance carriers and community service plans, such as Blue Shield and Blue Cross, will be forced out.
(2) *The independent medical practitioner will be no more.*
(3) Physicians, good and bad, will be herded together in mammoth facilities and possibly the facilities would eventually be controlled by the Federal Government.
(4) Doctors will be paid salaries or will get their divvy from the common pool of clinic funds.
(5) Cruikshank of the AFL sees great socialist potentials in the bills or he would not support them.

Careful study of the proposed legislation has brought us into complete agreement with Miss Shearon and other Washington analysts. The legislation is not only unnecessary but is a feeble political gesture on the part of the Administration to placate the little man and make him feel that his welfare is of primary concern. We feel that the President has been ill-advised on possible solutions of the problem and we are, of course, tremendously concerned about the effect the legislation and general socialistic trends would have on the people of the Territory.

Hawaii has recently been publicly designated as the location of a panel type medical plan and it is our sincere feeling that the introduction of such a plan is unnecessary when the doctors and hospitals of Hawaii have indicated that adequate services and health protection are available to the residents. Even if existing facilities and services of resident physicians were used, panel medicine would be practiced which eventually forces out the American "Free Choice of Physician" type of medicine and the independent practitioner.

For 16 years, HMSA—Hawaii's Blue Shield Plan—has operated as a community service and has worked closely with the doctors and hospitals to offer low-cost protection against the financial hardship which accompanies illness or injury. Progress has been made and is evidenced by the fact that benefits have been increased for the last three years without increasing the premiums.

Through the doctors and hospitals, your local non-profit medical plan is successfully meeting the problems of *good* health protection and it is anticipated that greater progress can be made in the future without government intervention or panel medicine. Today I believe a great challenge faces the hospitals and the doctors of Hawaii but knowing these people so well, I have the greatest confidence in their ability to safeguard our most cherished possession — our privilege to obtain good medical and hospital care from whomever or wherever we desire.

J. R. VELTMANN
*General Manager*

# Perhaps It's Your Nerves

## Treatment of Emotional Problems In General Practice

JOHN G. LYNN, IV, M.D.

This brief note cannot hope to discuss major techniques of psychotherapy. But if it serves to stimulate interest, sympathy, better understanding and cooperation in the use of minor psychotherapy for better medical care of sick people, it will have served its purpose.

The old time family doctor was uniquely successful in treating his patients because, although he had no knowledge of psychiatry, he knew them as individuals, their families, their backgrounds, their communities, and their day-by-day problems. He treated the person reacting to a disease. With increasing specialization of medicine and the growing preoccupation with certain areas of the body, the person having and reacting to the disease became more and more neglected. The specialty of psychiatry has brought into modern medicine a renewed emphasis on the importance of knowing a patient as a human being, if his emotional reactions are to be understood and the symptoms of his illness are to be properly treated.

The most essential understanding that the practitioner, or non-psychiatric specialist must have in order to adequately practice at least the minor aspects of psychotherapy are: first, an awareness of the existence in patients of unconscious motives and personality problems (e.g.: fears, hates, guilt, etc.) which can complicate and even cause medical disorders. Thus, tachycardia can be caused by repressed unconscious fear and anger, so that a slow convalescence in a hospital may be on the basis of an unconscious desire to avoid returning home and of a non-deliberate prolongation of the stay in the hospital. Such a motive, as the urge to stay in the hospital or fear of going home, may be very strong in the patient, and yet the patient may not be aware of it at all. Furthermore, the patient may not be aware of the fact that this motive increases his symptoms, such as muscle spasms, fatigue, asthma attacks, gastric contractions, discomforts, etc. He may, and usually does, have absolutely no understanding that his unconscious resentments and fears of going home aggravate these symptoms.

In performing his potential psychotherapeutic function, the practitioner has a responsibility of trying to help the patient rid himself of his crippling anxiety over repressed fears or angers, or in any case, to help him deal with them constructively. This he will do by helping him modify the unbearable situations of life at home or at work, or by attempting to modify the patient so that he can better tolerate these unbearable situations. Both of these procedures are considered minor psychotherapy and are essential in the practice of general medicine and non-psychiatric specialties. Let us examine these in more detail.

The practitioner may have found that the patient is faced with very real difficulties in his contemporary life. When these can be changed or alleviated they should be. This may involve working with the family to give them understanding of the illness to relieve their anxiety about the sick person; to give them confidence in the therapist's attempt to cure the illness; to discuss the problem of tangled emotional relations of husband, wife, parents; to help relatives to avoid overindulgence or over-severity; to act as a marital counselor; to help with problems of emancipation; to act as an impartial arbitrator in family disagreements; or to counsel in the sexual problems of husband and wife to the end that both have mutual satisfaction. A brief history from a close relative may throw additional and revealing light upon the patient's problems.

Much can be done in the evolution and correction of unhappy, distressful work and school adjustments. Employers need interpretations and are avid for them; as witnessed by the rapid growth of industrial psychiatry. It should be remembered that overwork rarely causes neurosis, although overwork at uncongenial tasks may aggravate it. Overwork is far more often a symptom of neurosis, than its cause.

In brief, where obvious, unbearable stresses exist in the actual contemporary life, they should be alleviated when feasible and practical. Suggestions are in order, but it is well to avoid too much regulation. The wise course is to help the patient come to his own decision regarding major and critical changes in his way of life, and to adhere to this non-directive role no matter how much the patient pleads for the physician's authoritative decisions.

Situational relief of the kind prescribed, while important, may be unfeasible or may be at best a partial procedure. Far more important is the effort to help the patient acquire inner security, freedom from anxiety and an enhanced capacity to meet the actual stresses. This is pre-eminently the listening therapy; psychotherapy in its more specific sense. The aim of this is to have the patient talk out, get verbal catharsis, relief, get his problem "off his chest," with the aim of getting greater understanding of his emotional life and difficulties so that he may manage himself more wisely and free himself of his crippling anxieties.

In this process, the physician will listen much more than he will talk. This can hardly be stressed too much. He must learn how to sit and just listen and he must forego the pleasure of hearing his own voice in order that his patient may freely have the time and freedom to say what is in him. He will invite full expression, and he will note whether talking brings any relief or merely upsets the patient. He will be guided in how far he can go and what topics to discuss by these observations. His task is not to dig out confessions, or premature discussion of sexual experiences, or even to delve into unconscious motivations. His aim is to create an atmosphere of trust and confidence wherein the patient will spontaneously bring into the discussion his sensitive, anxiety-laden experiences, memories and fantasies. As the history unfolds, he will recognize

that contemporary problems always have their prototype in early patterns of emotional feelings, habits and difficulties, particularly as they relate to childhood development, the powerful family constellation and the prevailing habits of response to family members. It is surprising indeed how quickly and spontaneously the contemporary difficulties give way to the discussion of the early life, with a heavy emphasis on the feelings and emotions experienced with parents and brothers and sisters. With this recognition by the patient that he is transporting early feeling tones and traumatic emotions to the contemporary people and situations, there may come a degree of insight that brings automatic relief from the present distress. More importantly, the healing comes automatically with the talking and the sharing with the understanding physician.

Some degree of explanation to the patient of these mechanisms may be needed. Similarly explanations of the nature of his symptoms and how they are expressive of repressed unconscious emotions may have to be given. The patient has to be taught these simple, to us, self-evident psychosomatic relations. They can be taught him by simple analogies; such as the somatic responses to talking in public, or to taking an examination, and he must then be brought to see the relation of his symptoms to the emotions he has been discussing. This is easy if he can be shown an increase in discomfort commonly occurs when he is in a situation of particular stress. This process is what is meant by the technical term "explanation." Hand-in-hand there goes a need for reassurance. Here the physician's authoritativeness and the patient's confidence gained through sharing in the physicians' examinations and findings are of prime importance.

From this simplified, brief discussion, it is to be hoped that the practitioner is convinced by now that all his patients would be improved by his appropriate attention to their emotional life. Nothing that one can say so briefly will make the practitioner an expert psychotherapist. It, however, may stimulate his desire to know more about the technique. If the doctor has achieved an attitude of tolerance towards these disabled people he will already have gained much. If he has determined to look for the emotional responses, even though they are not always evident or immediate, he is on the right track. This appeal is made that practitioners and psychiatrists work together for better medical care of human beings. It is an appeal that we can go forward together in an educational overture wherein both of us can profit. Let us at least begin the process of study and acquisition of knowledge, since only through the increasing psychotherapeutic skill of the practitioner and the psychiatric specialist can there be any hope for relief for the majority of patients with emotional causes or complications of their symptoms who make up two thirds of all medical liabilities.

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# Book Reviews

### A Manual on Cardiac Resuscitation.

By Robert M. Hosler, M.D., 183 pp., Price $4.00, Charles C. Thomas, 1954.

YOU MUST READ THIS BOOK—if you are (1) an anesthesiologist; (2) an endoscopist; (3) a house officer; or (4) a surgeon (occasional or frequent operator).

It contains in concise, readable, useable form the knowledge required to successfully resuscitate the patient following cardiac arrest. You can save your patient's life in this dramatic catastrophe, if you prepare yourself before it happens.

JAMES W. CHERRY, M.D.

### Diseases of the Liver.

By Mitchell A. Spellberg, M.D., F.A.C.P., 646 pp., illustrated, Price $16.50, Grune & Stratton, Inc., 1954.

It is not often one picks up a book as good as this one. The author has used a three-phase presentation. First there is a summary of the material; second, an excellent discussion; and third, an extensive bibliography to aid one in running down the minutiae of any subject desired. This, combined with numerous excellent illustrations, makes this a very valuable book for anyone interested in hepatology.

RAYMOND M. DEHAY, M.D.

### Children for the Childless.

Edited by Morris Fishbein, M.D., 223 pp., Price $2.95, Doubleday & Company, Inc., 1954.

This book, really a series of short essays by authorities in the field on the somatic, psychosomatic and social aspects of human fertility, is an authoritative, easily-read compilation. It not only covers the various procedures which may help sterile couples in conception but also covers adoption, genetics and words of wisdom concerning being a good modern parent.

The most interesting chapter is that on human fertility by Nicholson Eastman. It is a philosophic chapter backed with statistics and experience. It points out clearly what world population problems we have now and those that are to come.

C. C. MCCORRISTON, M.D.

### Poisoning.

By W. F. von Oettingen, M.D., Ph.D., 524 pp., Price $10.00, Paul B. Hoeber, Inc., 1952.

This is a comprehensive clinical reference by an established authority who has succeeded in incorporating all the material covering 461 toxic agents in a very usable format. The book is divided into two major sections, (1) signs and symptoms by systems, and (2) alphabetical index of toxicants.

This work appears to be the most definitive on the market, and is entirely up-to-date. The descriptive writing is straightforward and clear, and the treatment recommendations sensible.

LINUS PAULING, JR., M.D.

### A Formulary for External Therapy of the Skin.

By Chester N. Frazier, M.D., and Irvin H. Blank, Ph.D., 118 pp., Price $3.25, Charles C. Thomas, 1954.

The authors have presented a monograph describing the principles of treatment, cleaning the skin, ointment vehicles and emollients. A few pages are devoted to the mechanism and use of anti-pruritics, and anti-infective agents. The final chapter presents a dermatologic formulary free of nonsense and represents the results of much objectivity on the problem of external therapy of the skin.

There are several discrepancies of opinion throughout the text. Many dermatologists will disagree, for example, with the use of hexachlorophene in preference to the newer antibiotic ointments as an anti-infective drug.

The compend can be recommended to all dermatologists and others interested in the chemistry and mechanism of topical therapy.

HAROLD M. JOHNSON, M.D.

### Unipolar Lead Electrocardiography and Vectorcardiography.

By Emanuel Goldberger, M.D., F.A.C.P., Third Edition, 601 pp., illustrated, Price $10.00, Lea & Febriger, 1953.

This third edition is well written and illustrated and reads rather easily except for the chapter on the effect of the position of the heart on the normal electrocardiogram. I would advise the student of electrocardiography to have handy a model of the heart when studying this particular chapter. Particularly well written are the chapters on functional RS-T changes and bundle branch block.

A completely new section in this edition is the subject of vectorcardiography. The author describes several methods (which he has developed in the past 9 yrs.) by which vectorcardiograms can be derived and analyzed from the electrocardiogram.

I believe that this is one of the best books out on unipolar lead electrocardiography and would recommend it highly to anyone interested in cardiology.

ALBERT H. ISHII, M.D.

### A Primer of Congestive Heart Failure.

By George E. Burch, M.D., 126 pp., Price $4.00, Charles C. Thomas, 1954.

The first part of this monograph gives the present day concepts of the mechanism of cardiac failure with their limitations. The second portion offers a concrete program and outlines the dangers encountered in the management of congestive heart failure. Special attention has been given to the use of digitalis and the mercurial diuretics.

This monograph contains 102 pages and is written principally for the general practitioner.

HENRY C. GOTSHALK, M.D.

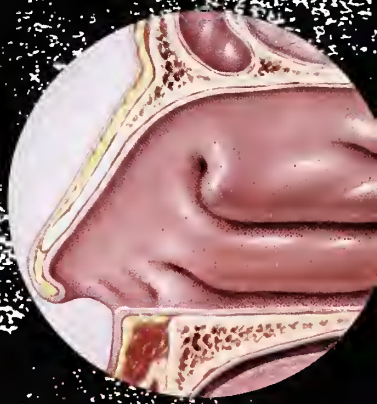
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**HYPERTENSIVE ISCHEMIC ULCER** of right leg in patient age 65. Ulceration refractory to treatment for 9 months, with patient complaining of severe pain. Treated with oral Priscoline, 50 mg. four times daily for four days and 50 mg. every four hours thereafter. Healing began with onset of Priscoline therapy and was complete in 10 weeks.

Increases blood flow to the extremities through a direct vasodilating effect on vessel wall, a sympathetic blocking effect, and an adrenolytic effect—

A valuable aid in the treatment of peripheral ischemia and its sequelae—pain, loss of function, ulceration, gangrene, and other trophic manifestations—

Priscoline hydrochloride available as 25-mg. tablets (scored), bottles of 100 and 1000; elixir, 25 mg. per 4 ml., in pints; 10-ml. multiple-dose vials, 25 mg. per ml.

PHOTOGRAPHS AND CLINICAL DATA BY COURTESY OF R. I. LOWENBERG, M.D., CONSULTANT IN VASCULAR SURGERY, CONNECTICUT STATE HOSPITAL, MIDDLETOWN, CONNECTICUT.

Priscoline® hydrochloride (tolazoline hydrochloride CIBA)

CIBA

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### Acute Renal Failure.

By John T. MacLean, M.D., 114 pp., illustrated, Price $6.50, Charles C. Thomas, 1952.

The author tells how the patient should be treated, beginning with the factors concerned in the production of acute renal failure until recovery occurs. The treatment is simplified and conservative. Doubtful methods are mentioned and explained. A detailed description of the use of the artificial kidney and what one hopes to accomplish with it are given. The use of ACTH and cortisone is very briefly summarized. The diagrams, with some in colors, the various colored plates, the pictures, the printing and the presentation of the subject matter make reading easy, simplified and understandable to any physician or surgeon who might be treating acute renal failure.

EDMUND ING, M.D.

### Mayo Clinic Diet Manual.

By the Committee on Dietetics of the Mayo Clinic, Second Edition, 247 pp., Price $5.50, W. B. Saunders Company, 1954.

The *Mayo Clinic Diet Manual* is probably one of the most widely referred to publications of its kind. The fact that it is a product of a renowned medical center is only one of its assets. The contents are organized and presented for efficient utilization and the dietary regimens included in the manual are specific for almost all of the diseases requiring any sort of dietotherapy.

There are various schools of dietotherapy. Hence, some of the practices advocated in the diet manual may be questioned; but with individualization of the diets for patients it could be termed "The Handbook of Diet Therapy."

The unmodified use of the dietary regimens in the *Mayo Clinic Diet Manual* may not be practical in Hawaii due to the cosmopolitan dietary habits of its people. For dietary treatments here, especially of chronic conditions, reference should be made to the *Hawaii Diet Manual.*

(MRS.) VIOLET T. HIRANAKA

### Progress in Fundamental Medicine.

Edited by J. F. A. McManus, M.D., 316 pp., illustrated, Price $9.00, Lea & Febiger, 1952.

This volume is composed of 9 authoritative discussions on subjects of current interest by authors who have distinguished themselves in these fields. There is a well-written and well-illustrated article by J. A. Cunningham on melanotic tumors of the skin, a discussion of the pathology of systemic lupus erythematosus by Paul Klemperer, an article on coronary artery disease by J. C. Paterson, and carcinoma in situ of the uterine cervix by L. D. Stoddard and W. K. Cuyler. J. P. Wyatt discusses non-silica pneumonoconioses; G. K. and T. B. Mallory have written on liver diseases, and Paul Cannon on recent advances in parenteral nutrition. Techniques for the histochemical approach to pathology by J. F. A. McManus, and the diagnosis of fungus infections with particular reference to staining methods by A. M. Kligman complete the volume.

A fairly comprehensive bibliography accompanies each discussion, and there are many good black and white illustrations and a few in color. The paper is of good quality. As a pathologist I have found this book particularly valuable, and I have had occasion to refer to it often.

I. L. TILDEN, M.D.

### Therapeutics in Internal Medicine.

Edited by Franklin A. Kyser, M.D., F.A.C.P., Second Edition, 830 pp., Price $15.00, Paul B. Hoeber, Inc., 1953.

This book presents a general coverage of therapy in internal medicine. The diseases discussed are presented by multiple authors and are grouped by systems except the infectious diseases which are presented under the various etiologic agents.

An entire chapter is devoted to the discussion of basic therapy in fluid and electrolyte problems. The inclusions of the newer antibiotics in therapy are presented; those that have been put out in the past one to two years are not included, however.

This book contains a great deal of information and covers its subject quite well.

GEORGE H. MILLS, M.D.

### Paying for Medical Care in the United States.

By Oscar N. Serbein, Jr., 543 pp., Price $7.00, Columbia University Press, 1953.

This book is a good reference book on cost of medical care and insurance coverage. It estimates that people of the U.S.A. spent eleven billion on illness in 1951. It answers much questions as: Where did the money come from? How was it used? Percent of population served? Percent of population in pre-pay plans such as commercial health and accident indemnity plans and Blue Cross and Blue Shield Service Plans? It factually discusses merits and deficiencies of each type plan but is spectacularly devoid of mention of Kaiser or Permanente plans. There is a wealth of tables, statistics and comparative costs and a final summary that estimates 75-80 percent may be the maximum of population ultimately covered by medical care insurance.

ROBERT B. FAUS, M.D.

### The Jealous Child.

By Edward Podolsky, M.D., 147 pp., Price $3.75, Philosophical Library, 1954.

This book is well written, concise, and adequately covers all possible phases of jealousy in childhood. It is easy to read, interesting, and readily understandable even to lay people.

Various stages of growth and development of the normal child and especially those afflicted with congenital malformation and disease-entity have been discussed in detail. Parental background, foster-parents, and step-children have been included. This book should find a place in one's library and is recommended to prospective parents.

FRANCIS K. CHU, M.D.

### Carcinoma of the Colon.

By Leland S. McKittrick, M.D., and Frank C. Wheelock, Jr., M.D., 94 pp., illustrated, Price $3.25, Charles C. Thomas, 1954.

This 90 page monograph, one of the publications of the American Lecture Series group, edited by Lester Dragstedt of the University of Chicago, is concise and very readable. Emphasis is placed upon the important elements in diagnosis and upon thoroughness of examination, with only brief comments regarding the operative management of these neoplasms.

This pamphlet can be unreservedly recommended for the student and to the general practitioner.

V. C. WAITE, M.D.

### Roentgen, Radium and Radioisotope Therapy.

By A. J. Delario, M.D., 371 pp., illustrated, Price $7.50, Lea & Febiger, 1953.

The author has accumulated and catalogued a vast amount of information from the radio-therapeutic literature. It has been set down in a very abbreviated form, as would be necessary since the text covers the detailed foundations of radiology from the ways in which radiation affects matter to the theory of the "hydrogen bomb."

Because of the fantastic amount of factual knowledge presented, parts of the book are difficult. It is similar to reading someone else's "notes" or "summaries." Hence the reader must already be familiar with the subject to appreciate many of the details. A number of the sections are views of only one school of thought, not always that which is generally accepted. This would apply particularly to his chapter on "Therapeutic Radiation Dose, and Diseases Amenable to Radiation Therapy."

The charts, tables, and graphs are a collection to make one's heart skip with joy. Since these are all well indexed, it is an ideal reference manual. The bibliography is extensive.

GEORGE W. HENRY, M.D.

## Also Received

### The Atom Story.

By J. G. Feinberg, M.Sc., 243 pp., illustrated, Price $4.75, Philosophical Library, Inc., 1953.

A non-mathematical narrative account of the atom from Democritus to the H bomb.

### Fifty Years of Medicine.

By Lord Horder, M.D., 70 pp., Price $2.50, Philosophical Library, Inc., 1954.

Reminiscences and philosophical speculations by a great British physician.

### Transference—Its Meaning and Function in Psychoanalytic Therapy.

By Benjamin Wolstein, Ph.D., 206 pp., Price $5.00, Grune & Stratton, Inc., 1954.

For psychiatrists.

### Physical Aspects of Betatron Therapy.

By John S. Laughlin, 98 pp., illustrated, Price $3.75, Charles C. Thomas, 1954.

This tells more about Betatron Therapy than most of us would like to know.

### The Medical Clinics of North America.

January 1954, Chicago Number—Emergencies in General Practice, pp. 1-318, figs. 1-19.

March 1954, Nationwide Number—Efficacy of New Drugs, pp. 319-636, figs. 20-55, $18 per clinic year, cloth binding; $15 per clinic year, paper binding, W. B. Saunders Company, 1954.

An excellent issue with emphasis on modern management of "stress" disorders.

### The Effect of ACTH and Cortisone Upon Infection and Resistance.

Edited by Gregory Shwartzman, M.D., 204 pp., illustrated, Price $5.50, Columbia University Press, 1953.

An important and authoritative reference work consisting of 14 essays by different authors.

### Amebiasis.

By Ernest Carroll Faust, Ph.D., 154 pp., illustrated, Price $4.75, Charles C. Thomas, 1954.

All about it, by a Professor of Tropical Diseases from Tulane.

### The Mechanism of Inflammation.

Edited by G. Jasmin, M.D., and A. Robert, M.D., 308 pp., illustrated, Price $8.50, Acta, Inc., 1953.

An important international symposium is reported in detail.

### The Uncommon Heart Diseases.

By Nathaniel E. Reich, M.D., 516 pp., illustrated, Price $10.50, Charles C. Thomas, 1954.

". . . a supplement to standard reference works on the heart," beautifully printed, with abundant illustrations and references.

### Atlas of Distribution of Diseases.

Rickettsial Diseases, Tick-borne and Mite-borne Forms, Price $1.25 per folded copy, $1.50 per flat copy, American Geographical Society, 1954.

Another in the series of excellent maps of the geographical distribution of diseases.

### Manual of Clinical Mycology.

By Norman F. Conant, Ph.D., David Tillerson Smith, M.D., Roger Denio Baker, M.D., Jasper Lamar Callaway, M.D., and Donald Stover Martin, M.D., Second Edition, 456 pp., illustrated, Price $6.50, W. B. Saunders Company, 1954.

Second edition of a concise, authoritative reference book, written by 5 collaborating authors, 4 of whom are on the faculty of Duke University. It is just about the best in its field.

### Current Therapy 1954.

Edited by Howard F. Conn, M.D., 898 pp., Price $11.00, W. B. Saunders Company, 1954.

Sixth of an annual series in which nearly 400 authors tell in a few words their method of managing almost every disease or symptom you can think of. Excellent and useful reference book for both general practitioners and specialists. Ask the man who owns one!

### Influenza—A Review of Current Research.

Contributed by C. H. Andrews, M.D., Sir Macfarlane Burnet, F.R.S., Z. Deutschman, Thomas Francis, Jr., M.D., Ross L. Gauld, M.D., M. R. Hilleman, Ph.D., Pierre Lepine, Preben von Magnus, M.D., J. Mulder, M.D., A.M.-M. Payne, M.D., C. H. Stuart-Harris, M.D., and Jacqueline H. Werner, M.S., 223 pp. Price $2.50, Columbia University Press, 1954.

Epidemiology, the virus, and control of this important potentially epidemic disease are discussed in 9 articles by authorities on these subjects. Interesting to the clinician and indispensable to the epidemiologist.

### Theory and Problems of Adolescent Development.

By David P. Ausubel, M.D., Ph.D., 580 pp., Price $10.00, Grune & Stratton, Inc., 1954.

A valuable reference book in this important subject.

### Digital Plethysmography.

By George E. Burch, M.D., F.A.C.P., 134 pp., illustrated, Price $5.00, Grune & Stratton, Inc., 1954.

Blood volume flow studies—beautifully presented but very technical.

# County Society Reports

## Hawaii

The May meeting of the Hawaii County Medical Society was called to order by Dr. T. Kutsunai, President of the Society, at 7:00 p.m. at the Hilo Hotel on May 27.

Members present were: Doctors M. H. Chang, H. E. Crawford, R. Kaufmann, T. Kutsunai, W. Loo, J. Matsumura, J. Mitchel, J. Mitchell, R. Miyamoto, G. Oakley, A. Orenstein, K. Ota, T. Oto, H. Paynter, I. Rothrock, G. Stemmermann, N. Steuermann, G. Tomoguchi, E. Wong, T. Woo, H. Yuen, R. Gray and J. Rutherford. Doctors J. Todt, E. Schmidt, J. Iaman and Lomi San were also present as guests.

Dr. Michael Gurdin, Plastic Surgeon, Los Angeles, California, gave an interesting talk on the emergency treatment of facial injury. Following this he answered questions concerning various problems in plastic surgery.

A short business meeting was held. Drs. H. Yuen and T. D. Woo, the Society delegates to the Territorial Medical Association meeting, reported upon the business meeting of that organization. There was a discussion of the recent proposal of the Kaiser Foundation to establish hospital facilities in Honolulu. It is reported that the Territorial Medical Association decided to give every possible support to the H.M.S.A. program in order that it may render as good or better service than that proposed by the Kaiser Foundation. The application of Dr. Dean Archer for membership in the Society was referred to the Board of Censors. Dr. George Oakley was elected to the Board of Censors for the term which expires in 1957.

It was decided that a fixed fee of $2.00 per injection be established for the proposed tetanus immunization program to be carried out at the request of the Territorial Civil Defense Agency. This is in line with the decisions of the County Societies on the other islands. The meeting was closed at 10:30 p.m.

* * *

A special meeting of the Hawaii County Medical Society was held on June 24, 1954.

Members present were: Drs. Bergin, Brown, Jenkin, Crawford, M. H. Chang, Kaufmann, Kutsunai, Leslie, Matayoshi, Mitchel, Miyamoto, Oakley, Okumoto, Orenstein, Ota, Paynter, Rothrock, Stemmermann, Steuermann, Willett, Wong, Woo, Yamanoha, Archer and Gray.

Mr. J. Veltman and Mr. A. Yuen from the Honolulu office of the H.M.S.A. presented an interesting discussion of the Kaiser Plan. They outlined its development and discussed the possibility of its coming to Hawaii. They gave an unbiased presentation of its good and bad points. They also presented a possible answer to the Kaiser Plan in the formation of comprehensive coverage by the combined hospitals and H.M.S.A.

At the close of the meeting a motion was made directing the secretary to write a letter to Dr. N. Larsen of Honolulu, giving him the wholehearted support of the Hawaii County Medical Society towards the development of such a comprehensive plan. This motion was made by Dr. R. Miyamoto and was seconded by Dr. I. Rothrock. The motion was passed unanimously by the Society.

A dinner meeting of the Hawaii County Medical Society was held at the Yacht Club on June 30, 1954. Drs. M. H. Chang, Crawford, Hata, Henderson, Kasamoto, Knotts, Kutsunai, Leslie, Loo, Mitchel, Miyamoto, Oakley, Okumoto, Orenstein, Oto, Paynter, Rothrock, Stemmermann, Steuermann, Tomoguchi, Woo, Yamanoha, Yuen, Archer, Gray and Schmidt were in attendance.

The speaker of the evening was Dr. Bruce K. Wiseman. He addressed the Society on the subject of "Hypersplenism."

This was followed by a short business meeting during which Dr. Archer was officially elected to membership in the Society.

GRANT N. STEMMERMANN, M.D., *Secretary*

## Kauai

The regular monthly meeting of the Kauai County Medical Society was held April 13, 1954, at 7:30 p.m., Dr. Peter Kim presiding.

Members present: Doctors Yamauchi, Masunaga, Goodhue, Wallis, Cockett, Fujii, Wade, Kim, Brennecke and Boyden.

Mrs. Kay Hardy of the Cytological Laboratory spoke briefly of the work done.

Our delegate to the Hawaii Medical Association was instructed to use his judgment in voting on the "Tennessee Plan" for Veterans and the "Iowa" Resolution regarding the Code of Ethics.

Dr. Wade reported on the last H.M.S.A. meeting, among other subjects, mentioning a plan for catastrophic illnesses under consideration. Also discussed was the possibility of adopting a uniform fee schedule for the Territory.

The handling of U. S. Life vouchers was taken up. Action: Since these are, in fact, privileged communications, a motion was unanimously passed, that these vouchers be mailed by the physician directly to the carrier.

Mr. Norman Moore, Federal Consulting Architect, covered the plans and specifications of the proposed new hospital at Waimea. A full and general discussion followed.

The Territorial voluntary tetanus immunization was discussed. The program was endorsed and a maximum fee of $2.00 for each injection was adopted.

Dr. Kemp of the Territorial Board of Health presented two subjects:

(1) Under the Fetal Waste Studies, the Society gave its approval to a trimester visit by a Board of Health nurse to those women under observation to ascertain the course of the pregnancy. A check list was to be prepared and an opportunity given the Society to discuss it.

(2) An in-training program for pre- and post-natal postural training was presented. A motion was passed to the effect that the Society had no objection to the plan being tried for one year.

* * *

A special meeting was held on the evening of Tuesday, April 27, 1954, President Peter Kim presiding. Present were: Doctors Ishii, Wade, Cockett, Wallis, Yamauchi,

Kim, Masunaga, Fujii, Boyden, Resident Dr. Strongman, and Dr. Conn of Ann Arbor, guest speaker of the evening.

Communications were read, explaining a proposed Cancer Survey in the Territory. It is planned to have all the proven cases of cancer of the stomach interviewed with the object of trying to learn something of the etiology of the disease. Such a survey was approved in principle.

The meeting was then turned over to Dr. Conn who gave a very interesting and informative talk on the various forms of spontaneous hypoglycemia.

* * *

The regular meeting of the Kauai County Medical Society was held on May 11, 1954 at 7:45 p.m. Meeting was called to order by Dr. Peter Kim.

Members present: Doctors Cockett, Masunaga, Kuhns, Goodhue, Fujii, Wallis, Ishii, Brennecke, Kim, and Yamauchi. Guest present was Dr. Connor.

A request from the Cancer Society to have one of the local doctors participate in monthly radio question and answer programs in Japanese was approved providing a volunteer doctor is obtained.

Dr. Connor gave a report on the progress of the Fetal Death Survey. She urged the participating doctors to make pregnancy reports as soon as possible. Dr. Brennecke suggested that the Public Health send monthly communications to the doctors regarding the progress of the Fetal Study.

* * *

The regular monthly meeting of the Kauai County Medical Society was held at the Wilcox Memorial Hospital June 8, 1954 at 7:30 p.m., Dr. Peter Kim presiding. Members present were Drs. Yamauchi, Masunaga, Cockett, Fujii, Kim and Boyden. Dr. Schilling, Medical Assistant at Mahelona Hospital, was a guest.

Drs. Cockett and Kim reported on the meetings of the House of Delegates at the recent Territorial meeting.

The society voted approval of an otologic program for 4-year-old children on Kauai and a somewhat similar program in the public schools. For the past three years audiometric examinations have been conducted in the second grades on Kauai by the local chapter of the National Society for Crippled Children and Adults. Out of the 1,500 children tested, 5% indicated medically significant hearing losses.

WEBSTER BOYDEN, M.D.
*Secretary*

## Maui

The regular meeting of the Maui County Medical Society was held at the Central Maui Memorial Hospital on Thursday evening, April 15, 1954.

Those present were Doctors A. Y. Wong, Fleming, Kashiwa, Ohata, Kanda, St. Sure, Sanders, Cole, Tompkins, Ferkany, Patterson, Underwood, Rockett, Izumi, Rose, Tofukuji, Shimokawa, Knox, Burden, McArthur and Kushi.

Guests present were Doctors Berk and Hartwell and Dr. Faus, Mrs. James and Mr. Young from the H.M.S.A.

A request from the Maui Auxiliary for permission to undertake a project of writing biographies on past deceased members of the Society was read and the request was granted unanimously.

The business meeting was then given over to the representatives of the H.M.S.A. Dr. Faus and Mr. Young of the H.M.S.A. gave a short report of the status of the H.M.S.A. A plan covering catastrophic illness in conjunction with the H.M.S.A. policy was outlined.

The balance of the meeting was turned over to Drs. Berk and Hartwell. Dr. Berk spoke on "Arrhythmias" and Dr. Hartwell spoke on the topic "Differential Diagnosis of Chest Pains." Question and answer period followed and all in all the session was enjoyed by everyone present.

* * *

A special dinner meeting of the Maui County Medical Society was held at the Central Maui Memorial Hospital on April 29, 1954.

The special speaker of the evening was Dr. Jerome W. Conn, Professor of Medicine at the University of Michigan, who gave an excellent and revealing talk on Hypoglycemia. We thanked Dr. Conn for this enlightening talk.

H. KUSHI, M.D., *Secretary*

# Notes and News

## PERSONALS

**Dr. Ralph B. Claward** recently returned from the 9th Congress of the International College of Surgeons, held at Sao Paulo, Brazil. At the congress he was chairman of the section of neurological surgery and presented a paper on "The Degenerated Disc." While in South America Dr. Cloward addressed the medical societies and performed demonstration operations in Buenos Aires, Montevideo and Sao Paulo. He was presented with a certificate of honorary membership from the Peruvian Academy of Surgery at Lima, Peru and an honorary degree from the University of Sao Paulo, Brazil.

After his return to the islands, Dr. Cloward received an offer from the University of Chicago as professor of neurological surgery. He accepted the honor for a six months' period starting July 1. Dr. Cloward left June 15 to attend the A.M.A. convention in San Francisco where he had an exhibit on the Treatment of Ruptured Intervertebral Discs and read a paper on Spondylolisthesis. He proceeded from there to Chicago, and plans to return to the islands by January 1, 1955.

**Dr. Thomas S. Bennett** and **Dr. Jahn Lawrey** attended the annual meeting of the Harvey Cushing Society held in Santa Fe, New Mexico.

**Dr. G. H. Mills,** formerly chief medical resident at The Queen's Hospital, joined the Alsup Clinic on July 8. Dr. Mills has also been appointed as physician for the Kamehameha Schools.

Attending the San Francisco convention of the A.M.A. were **Drs. Richard Dodge, Teru Tagasaki, F. J. Pinkerton, Ralph B. Claward, Hamer M. Izumi, William Jahn Halmes, H. Q. Pang, L. Q. Pang, Robert Bailey, Abraham Ng Kamsat, Harald Sextan, Robert H. Lee, Walter Chung, Cliffard Kobayashi, C. C. McCarriston, Henry Gatshalk, R. B. Faus, Edmund Lee** and others.

**Drs. Ruth Sisan, H. Joseph Siman, George H. Hodel, Dean Rabbin Archer and James G. Harrisan** recently combined to form The Psychiatric Group with offices at the King Kalakaua Building. In order to render a complete psychological service, the group has employed three psychologists. Though each of the physicians practices general psychiatry, each of them is interested in various subspecialties. These include adolescent and adaptive problems, child psychology, neuroses, psychoses, problems related to marriage, psychoanalysis, psychosomatic diseases and the like.

**Dr. Nils P. Larsen,** newly elected president of the Hawaii Medical Association, was presented the William Knudsen Award for outstanding contributions to industrial medicine. The award, a bronze plaque, was given Dr. Larsen by the Industrial Medicine Association.

**Dr. Francis T. C. Au** has been awarded a fellowship at the Lahey Clinic in Boston.

**Dr. K. Kuramota** has returned to his practice of internal medicine in the Medical Arts Building after serving two years' active duty with the Army in Tokyo and Taegu.

**Dr. L. M. Mapp,** of the resident staff of St. Francis Hospital, left for a year of graduate work in obstetrics and gynecology at the University of Pennsylvania in Philadelphia.

**Dr. Harry L. Arnald, Sr.** was elected Chief of Staff of The Queen's Hospital. He will also serve in an ex officio capacity on the Board of Directors of the hospital.

**Dr. Min Hin Li** has been elected temporary president of the Lee Association of Hawaii.

**Dr. H. Uchiyama** announces the new location of his office at 931 Keeaumoku St.

Congratulations are extended to **Dr. and Mrs. Thamas Cowan** on their 25th wedding anniversary.

**Dr. Lawrence Lit Lau, Jr.** is now associated with Dr. H. Q. Pang in the general practice of medicine at 52 So. Vineyard. Dr. Lau is a graduate of Punahou School and received his M.D. from Stanford University Medical School. He served his internship at San Francisco City and County Hospital followed by a general medical residency at the University of Colorado Medical Center and an additional year of residency in radiology at Michael Reese Hospital in Chicago. During the war Dr. Lau saw service in New Guinea, Philippines and Japan.

**Dr. Mary A. Glover** announces the opening of her office for general practice of medicine and surgery at 45-504 Kamehameha Highway, Kaneohe.

**Dr. B. Allen Richardsan** addressed the Occupational Therapy Association of Hawaii on "The Relation of Orthopedics to Occupational Therapy."

**Drs. William Cady and Radger Bennett,** members of the staff of the Territorial Hospital at Kaneohe, spoke at the St. Christopher's Episcopal Church in Kailua on "Your Child's Mental Health."

**Dr. Robert A. Kimmich,** medical director of the Territorial Hospital, conducted a survey of mental diseases in Guam. The trip was sponsored by the government of Guam.

**Drs. Geargе Tyau and Edmund Ing** announce the removal of their offices to 919 Keeaumoku Street.

**Dr. Cecil A. Saunders, Jr.** announces the removal of his offices to 309 So. Vineyard, temporarily with Dr. K. M. Amlin.

Four members of the Hawaii Medical Association discussed cancer on a recent symposium on television. The group included **Drs. Richard Maare, Grover H. Batten, Herbert Y. H. Chinn and W. Harold Civin.**

**Dr. Carl H. Lum** recently received his M.D. degree from the University of Illinois and started his internship at the Cook County Hospital in Chicago. Dr. Lum won a nationwide contest among medical students sponsored by the Schering Corporation with a paper entitled "New Concepts in the Treatment of Peptic Ulcer."

**Dr. Hamer Izumi** was elected a Fellow of the American College of Chest Physicians.

**Dr. Frank Spencer** showed his movie, "Conization of the Cervix Uteri with a Simplified Technique," at the June meeting of the Pacific Northwest Obstetrical and Gynecological Society in Portland.

**Drs. Herbert G. Pang, Frederick M. K. Lam and Richard S. F. Lam** have been called to active service with the Army. **Dr. Jack Waadruff** has been called to active duty with the Navy.

The Queen's Hospital has been awarded a grant by the Harvey Bassett Clark Foundation for research on the effect of trace elements in sea water on growth and development. **Dr. Harald Civin** will be in charge of these investigations.

## ROBERT NOAH PERLSTEIN, M.D.
## 1901 - 1954

An exceptionally gifted physician was lost to Leahi Hospital, to Hawaii, and to his countless friends when Bob Perlstein, Assistant Medical Director of the hospital, succumbed to his second coronary occlusion on May 24, 1954, at the age of 52.

Born in Grodno, Poland, and a naturalized U.S. citizen, Bob took his medical degree at New York Medical College in 1924, and after an interneship and residency in Los Angeles, came to Honolulu as Resident Physician at Leahi Hospital in 1928. He became Associate Medical Director in 1945, and Assistant Director in 1951.

Though he was never sufficiently sympathetic with the purposes and methods of organized medicine to take an active part in medical society affairs, Bob was a member of the Honolulu County Medical Society, and had served on its Board of Governors; he had also been active on the Scientific Works Committee of the Hawaii Medical Association, and its chairman at one time. He read original papers before the Society on several occasions, and his presentations were always distinguished for the thoroughness of preparation and clarity of presentation.

Bob was one of those rare combinations of a brilliant intellect, a keen sense of humor, and a warmly compassionate personality. His insatiable curiosity about matters related to his life's work, phthisiology, led him to master such subjects as electrocardiography, biostatistics, medical mycology, anesthesiology, and cardio-respiratory physiology. With Dr. William F. Leslie, he had invented a three-way pneumothorax machine and an anesthetic machine, and at the time of his death he was working on an electronic tachometer for measuring respiratory air exchange. He was an exceptionally skillful chess player. He was well and widely read, not only in the professional literature in his own and other medical fields, but in philosophy, history and fiction. His life was too full for the "itch to write" to trouble him; but though he wrote only infrequently, he wrote clearly, plainly, and exceptionally well. He was a conversationalist of unusual ability, and loved a discussion of controversial issues; indeed, he was perfectly capable of defending a view he did not believe in, just for the fun of it.

For all his strong scientific and investigative bent, he was an outstandingly kindly and sympathetic physician, deeply loved by the thousands of tuberculosis patients who came under his care and in many instances owed their lives to him. He contributed immeasurably to Hawaii's exceptionally effective tuberculosis treatment and control program, and to the pre-eminence of Leahi Hospital as a modern tuberculosis hospital.

Bob is being missed, and sorely missed; but Leahi is so thoroughly permeated with his individuality and personality, and his memory is so vivid there in so many ways that—as a nurse on the staff remarked—"It seems as if he's just gone away for a few days and he'll be back pretty soon. We can hardly believe he's gone." Of this is made the most worthwhile kind of immortality. Bob Perlstein earned it, many times over.

HARRY L. ARNOLD, JR., M.D.
HASTINGS H. WALKER, M.D.

**Dr. Clarence E. Fronk** was elected chairman of the Board of Directors of the newly formed Adventurers Club of Honolulu.

**Dr. Max Levine,** director of laboratories of the Territorial Department of Health, addressed a conference of State and Territorial Public Health Laboratory Directors in Atlanta, Georgia. He also participated at the Annual Meeting of the American Society of Bacteriologists at Pittsburgh, Pa.

**Dr. Richard K. C. Lee,** president of the Territorial Board of Health, outlined the federal Foreign Operations Administration program to members of the West Rotary group of Honolulu.

In the April issue of *Public Health Reports,* Dr. Lee reviewed over a century of the public health program in Hawaii. In his article, Dr. Lee calls attention to the fact that communicable disease rates in Hawaii are lower than anywhere else in the world.

**Dr. James R. Bobbitt,** formerly with the Straub Clinic, has returned to Pasadena, where he plans to join his father in the practice of otolaryngology.

### Hawaii

**Dr. William Bergin** attended the San Francisco conference of the American Academy of General Practice.

**Dr. S. Mizuire** writes from Chicago that he is busy, happy, but homesick. He is studying cardiovascular surgery at the Cook County Hospital. His return to the Big Island is eagerly awaited.

**Dr. E. Schmidt** began work as the full-time radiologist at the Hilo Memorial Hospital on May 1, 1954. He has already made himself indispensable.

**Dr. Richard Yamanoha** has been discharged from the Kuakini Hospital and is now convalescing. We hope to see him back on his daily rounds as quickly as possible.

At the meeting held in conjunction with the visit of the Territorial Public Health Department to this island, the need of new general facilities was elaborated. **Drs. Steuermann, Crawford, Leslie, Stemmermann** and **Woo** contributed to the discussion. The proposed plan to erect a general hospital wing in association with the present Puumaile Hospital, followed by the moving of the Old Folks Home to the present Hilo Memorial Hospital building, was described and justified.

## Kauai

**Dr. and Mrs. Eichi Masunaga** left for the A.M.A. Convention June 18 where Dr. Masunaga expected to meet some of his classmates, Washington University, Class '43.

The Masunagas were especially interested in visiting the American Physicians' Art Association. The doctor has been a member of the association since 1946 and this year sent two pieces of his metal art work for the show.

Before returning home, Dr. and Mrs. Masunaga spent a short time in Mexico.

**Dr. Stanley Schilling** has recently come to Kauai as Medical Assistant at Samuel Mahelona Memorial Hospital. He graduated from University of Vermont College of Medicine in 1952 and interned at Wisconsin General Hospital at Madison. Prior to coming to Mahelona, Dr. Schilling held a fellowship in General Practice at Monroe Clinic, Monroe, Wisconsin. He spent two years in the Coast Guard, 1947 and 1948.

**Dr. Peter Kim,** Medical Director of Mahelona Hospital, was in Hilo, June 12 to 27, with the 483rd F.A. Battalion, H.N.G.

**Dr. and Mrs. Sam Wallis** were in San Francisco from June 19 to 29. Dr. Wallis attended the A.M.A. Convention.

On June 12 **Dr. and Mrs. Webster Boyden** flew to San Francisco where Dr. Boyden attended the American Medical Association Meetings.

Their son Blaine, a student at Western Reserve Medical School in Cleveland, Ohio, joined them on June 17 for a week's visit before leaving for Glacier National Park where he will work this summer.

The Boydens returned the first week in July.

**Dr. Burt O. Wade** of Waimea left the end of May for a visit at the Mayo Clinic and with friends in Kalamazoo. From Michigan he drove to the west coast to see his son Wellesley at La Sierra College in California. He also attended the A.M.A. meeting.

## NEWS

### American College of Gastroenterology

Final steps in the activation of the American College of Gastroenterology were taken by the Fellowship of the National Gastroenterological Association at a special meeting recently held in New York City.

At this meeting, it was voted to transfer the membership of the National Gastroenterological Association, classified as to their present status, to the American College of Gastroenterology. A transfer of all the assets including the official publication, The American Journal of Gastroenterology, to the College was also voted upon.

Information concerning membership in the American College of Gastroenterology may be obtained by writing to the Executive Secretary, American College of Gastroenterology, 33 West 60th St., New York 23, N.Y.

### Sixth Congress on Obstetrics and Gynecology Set for December 13-17

The sixth American Congress on Obstetrics and Gynecology will be held at the Palmer House, Chicago, December 13-17, 1954.

The program will include twenty-seven formal papers, twenty-two symposia and panels, luncheon discussion groups, and several hundred round-table discussions, covering every phase of maternal and newborn care. Scientific and technical exhibits are also being planned.

Information about the meeting may be obtained by writing to the Sixth American Congress on Obstetrics and Gynecology, 116 South Michigan Avenue, Chicago 3, Illinois.

### Course in Postgraduate Gastroenterology

The National Gastroenterological Association announces that its Sixth Annual Course in Postgraduate Gastroenterology will be given at The Shoreham in Washington, D.C. on October 28, 29, 30, 1954.

The course will again be under the direction of co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Director of Medical Education, Beth-el Hospital, Brooklyn, N. Y., who will serve as medical co-ordinator.

Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools and Walter Reed Army Hospital, whose presentations will cover all phases of gastrointestinal diseases and problems.

The entire session on Friday, October 30, 1954 will be given at the Walter Reed Army Hospital.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 33 West 60th Street, New York 23, N. Y.

### National Society for Crippled Children and Adults

The 1954 convention of the National Society for Crippled Children and Adults will be held November 3-5, at the Statler Hotel, Boston.

### To Those Interested in Cytology

The second annual meeting of the Inter-Society Cytology Council will be held in Boston, Friday and Saturday, November 12 and 13, 1954. Those having material to present are invited to submit three copies of the title and an informative abstract of not more than 200 words to Dr. John B. Graham, Chairman of the Program Committee, 32 Fruit Street, Boston, Massachusetts, before July 15 ,1954. Abstracts of all papers accepted will be published in the official program.

The diagnostic accuracy in cancer of the cervix and the lung is so well established that further verification at this meeting is not indicated. Particular attention is suggested for the endometrium and lesions of the gastrointestinal and urinary tract.

The Scientific Program will comprise four consecutive sessions: Special Techniques, including Cytochemistry, Ultra-violet and Electron Microscopy; Prognosis in the Treatment of Cancer by Cytologic and Histologic Techniques; New Developments in Cytology, and Round Table Discussion of the Carcinoma In-Situ Lesion.

### American Occupational Therapy Association

The 37th Annual Conference of the American Occupational Therapy Association will be held at the Shoreham Hotel, Washington, D.C., October 16-22, 1954. The meetings will be as follows:

Preliminary Meetings
Institute—Interpersonal Relations
General Conference—Theme: "Capitalize your Assets"

# Ninety-eighth Annual Meeting
# Hawaii Medical Association

**Honolulu, Hawaii**
**May 13 through 16, 1954**

The ninety-eighth annual meeting of the Hawaii Medical Association was held in Honolulu, Hawaii, with scientific meetings and exhibits in the Mabel L. Smyth Memorial Building. The following program was presented:

## SCIENTIFIC PROGRAM

*Movie—Translumbar Arteriography*
Herbert Y. H. Chinn, M.D.

*Retinal Lesions in Systemic Lupus Erythematosus: Report of Two Cases*
Thomas W. Cowan, M.D.

*Retrolental Fibroplasia in Prematurity*
O. D. Pinkerton, M.D.
Discussant: Colonel Austin Lowrey, Jr., M.C., U.S.A., Chief of Ophthalmology, Tripler Army Hospital

*The Genetic Analysis of the Deaf in Hawaii*
Tadao Hata, M.D.
Discussant: Isaac Kawasaki, M.D.

*Esophageal Voice*
Albert K. T. Ho, M.D.
Discussant: Wesley D. Hervey, M.A., Instructor of Speech, University of Hawaii

*Recognition of Otosclerosis and Its Treatment*
John P. Frazer, M.D.

*A Study of the Racial Frequency and Age Distribution of Ovarian Tumors in Honolulu*
Lionel M. Mapp, M.D.
Discussants: H. E. Bowles, M.D.; K. S. Tom, M.D.

*Needle Liver Biopsy: Its Uses and Contraindications*
Raymond deHay, M.D., Emiko Sakurai, M.D., and Harold Civin, M.D.

*Survey of the Far East Combat Theater*
F. J. Pinkerton, M.D., Consultant in Oto-Ophthalmology for the United States Armed Forces

*Recent Trends in the Management of Head and Neck Malignancies*
Grover H. Batten, M.D.

*Atherosclerosis in Relation to Race, Age, Sex and Diet*
Nils P. Larsen, M.D.

*Racial Differences in the Frequency of Cancer in Hawaii*
Walter B. Quisenberry, M.D., I. L. Tilden, M.D., and Jerome Rosengard, M.D.

*Bone Trauma and Delirium Tremens*
J. Robert Jacobson, M.D.

*A New Aspect of Treatment in Psychosomatic Disorders*
William H. Stevens, M.D.

*A Successful Treatment for Infantile Eczema*
F. D. Nance, M.D.

*Movie—Vertebral Body Fusion for Ruptured Lumbar Discs*
Ralph B. Cloward, M.D.

*Pain—The Importance of Its Proper Evaluation*
J. Warren White, M.D.

*Pharyngoesophageal Diverticula: Their Diagnosis and Treatment*
Laurence M. Wiig, M.D.

*Freedom—Our Guiding Light*
Presidential Address by Edwin K. Chung-Hoon, M.D.

*Audio-Digest Film—What's New in Medicine*

*The Endocrine and Metabolic Response of Man to Stressing Circumstances and Their Clinical Implications*
Jerome W. Conn, M.D., Professor of Medicine, Division of Endocrinology and Metabolism, University of Michigan Medical School

## MEETINGS

*Council,* Wednesday evening, Oahu Country Club.

*House of Delegates,* Thursday and Friday mornings, Mabel Smyth Auditorium.

*Woman's Auxiliary*—House of Delegates, Thursday evening, home of Mrs. Garton E. Wall.
Annual membership meeting, Friday morning, Racquet Club, Kailua.

*Hawaii Territorial Academy of General Practice,* annual meeting, Saturday morning, Oahu Country Club.

## SOCIAL PROGRAM

*Cocktails and annual banquet,* Saturday evening, Oahu Country Club.

*Golf tournament,* Sunday morning, Waialae Country Club.

*Woman's Auxiliary buffet luncheon,* Sunday noon, Hau Lanai, Halekulani Hotel.

*Picnic for doctors.* Sunday afternoon, homes of Dr. Donald Depp and Dr. William Stevens.

## NOTES

Scientific papers presented have been submitted for publication in the HAWAII MEDICAL JOURNAL.

The Golf Tournament was won by Dr. S. C. Culpepper.

## PROCEEDINGS

The minutes of meetings and reports follow:

## MINUTES OF COUNCIL MEETING

**Wednesday, May 12, 1954 at 6:00 p.m.**
**Oahu Country Club**

*Present:* Dr. Chung-Hoon, presiding; Drs. N. P. Larsen, Samuel L. Yee, Richert, Ito, Gotshalk, Sanders (Maui), Homer Benson, Yuen (Hawaii), McArthur (Maui); also Drs. Izumi and Dodge, Mr. Kennedy and Mrs. Bennett.

*Minutes:* The minutes of the Council meeting of February 2, 1954 were approved.

*Centennial Celebration Committee:* Suggestions for the membership and responsibilities of the Centennial celebration committee were discussed by the Council.

**ACTION: The present vice president, secretary and treasurer of the Honolulu County Medical Society were included as members of the Centennial celebration committee.**

**ACTION: The Council agreed to allot $5,000 to cover expenses incidental to the Centennial celebration.**

The Council recommended to the House of Delegates:

1. That the Delegates approve the duties of the committee as outlined by the officers.
2. The sum of $2500 to be drawn upon this fiscal year as needed by the committee and a like sum for the following year.
3. The appointment of members of this committee as outlined by the officers with the addition of the

present vice president, secretary and treasurer of the Honolulu County Medical Society as members, and the following as additional source members: Dr. L. L. Sexton, Dr. Homer Hayes, Dr. Eric Fennel and Dr. Frank Putman.

*Finances:* Dr. Richert reported that the services of Messrs. Leman and Hough in auditing the accounts for the fiscal year have been very satisfactory.

**ACTION: Leman and Haugh were retained as auditars far the accaunts of the Hawaii Medical Assaciation far the fiscal year 1954-55.**

Dr. Richert reported that the auditors recommended that a portion of the checking account be placed in an interest bearing investment.

**ACTION: The Council autharized the treasurer, with the advice af the auditars, ta invest an appropriate sum from the checking accaunt in arder ta abtain some interest during the year.**

**ACTION: The fallowing budget far the fiscal year was approved by the Cauncil with an expressian af appreciatian ta the treasurer.**

**BUDGET—1954-1955**

| | |
|---|---|
| INCOME | |
| Dues | $10,050.00 |
| Journal Advertising | 11,600.00 |
| Journal Subscriptions | 2,700.00 |
| Annual Meeting | 2,500.00 |
| Interest | 50.00 |
| Miscellaneous | 165.00 |
| | $27,065.00 |
| EXPENSES | |
| Journal Costs | $12,000.00 |
| Audit | 85.00 |
| Postage | 260.00 |
| Rent | 1,128.00 |
| Salaries | 9,225.00* |
| Supplies | 300.00 |
| Taxes | 275.00 |
| Telephone & Telegraph | 275.00 |
| Travel | 200.00 |
| AMA Convention | 1,975.00** |
| Medical Library | 100.00 |
| Miscellaneous | 250.00 |
| | $26,073.00 |
| Centennial Celebration | 2,500.00 |
| | $28,573.00 |

* Includes entire salary for Mrs. Florence Sueoka plus an increase of $10 per month in her salary beginning May 1, 1954.
** Includes first class travel for both conventions, refund to be made if tourist class is used.

*Hawaii Medical Journal:* It was reported that the Honolulu County Medical Society had suggested the inclusion of its annual reports in the HAWAII MEDICAL JOURNAL. Mrs. Bennett reported that this would cost approximately $175.

**ACTION: The Council autharized the Editar ta use his discretian as ta haw much af the caunty saciety reparts and news should be included in the HAWAII MEDICAL JOURNAL. The matian was passed with twa appasing vates.**

Dr. Arnold had recommended in his annual report of the HAWAII MEDICAL JOURNAL that consideration be given to the appointment of an assistant editor. This was discussed and it was brought out that neither Dr. Arnold nor any member of the Council knew of any doctor who was well qualified and interested in assuming such responsibility. However the matter will be kept in mind so that such a position may be created when a suitable applicant may be found.

**ACTION: A vate af canfidence in Dr. Harry L. Arnald, Jr., Editar af the HAWAII MEDICAL JOURNAL, was unanimausly passed.**

Dr. Gotshalk felt very strongly that the duties of the editorial board should be specifically outlined. He felt that this group should be the governing body of the JOURNAL.

**ACTION: A matian that the editarial baard appainted by the Cauncil should be asked ta wark with the Editar in autlining the specific duties af the editarial baard and submit recammendatians ta the Cauncil for consideratian at its next meeting was passed with ane appasing vate.**

It was suggested by Dr. Gotshalk that the organization of the HAWAII MEDICAL JOURNAL be set up in the same form as that of the *New England Journal of Medicine.*

**ACTION: The Cauncil appainted the fallawing Journal Editarial Baard far the year:**

Harry L. Arnold, Jr., M.D., Editor
Mrs. Edith C. Bennett, Managing Editor
William John Holmes, M.D., News Editor
Fred I. Gilbert, Jr., M.D., Contributing Editor
Nils P. Larsen, M.D., Advisory Board
Hastings H. Walker, M.D., Advisory Board
Homer M. Izumi, M.D., Advisory Board
Grant N. Stemmermann, M.D., Associate Editor, Hawaii
Louis S. Rockett, M.D., Associate Editor, Maui
A. Webster Boyden, M.D., Associate Editor, Kauai

**ACTION: It was vated that as a very slight taken af appreciatian af the great service ta the Assaciatian perfarmed by Dr. Harry L. Arnold, Jr., as Editar, his expenses during this annual meeting shauld be barne by the Associatian.**

*Tetanus Immunization:* A program of tetanus immunization throughout the territory has been proposed as a civil defense measure to be carried on this summer with adequate publicity. The Honolulu and the Kauai County Medical Societies had approved of this program and agreed that the doctors would not charge more than $2.00 per injection during this program.

**ACTION: The Council approved af the tetanus immunizatian program in the Territary far this summer.**

*Kaiser Health Program:* Dr. Dodge, chairman of the Industrial Relations Committee, reported that Mr. Vance Fawcett, Public Relations representative for Mr. Kaiser, had informed him that Mr. Kaiser was interested in talking with his committee about possible health plans for Hawaii. The committee met with Mr. Kaiser and listened to his explanation of why he considered establishing a health plan in Hawaii. He stated that he has been interested in improving health conditions for many years and he was particularly concerned about the present financial plight of Kapiolani Hospital. He also mentioned that union leaders indicated an interest in his plan here. It was his statement that he wanted to use local doctors and did not expect to import doctors from the mainland to start this plan. Mr. Kaiser also said that his plan would be open to anyone and he stated that the Kaiser Foundation is a non-profit organization whose income is used for charity and training.

There was much discussion about the Kaiser plan and the doctors felt that the matter should be weighed very carefully before forming an opinion or making any statement.

*Adjournment:* There being no further business, the meeting was adjourned at 10:22 p.m.

SAMUEL L. YEE, M.D.
*Secretary*

## MINUTES OF MEETING HOUSE OF DELEGATES

**Thursday, May 13, 1954 at 8:00 a.m.**
**Mabel Smyth Building**

*Present:* Dr. Chung-Hoon presided. There were 46 members of the Association present, including the following delegates and alternates: Drs. Burgess, Kim (Kauai), S. L. Yee, Richert, Woo (Hawaii), Hayashi

(Hawaii), Bailey, Choy, Gebauer, Marnie, Wiig, J. Bell, Cushnie, Devereux, Ito, Johnson, Lowrey, Gilbert, Edmund Ing, Nelson, L. Q. Pang, Bachman, deHay, Morgan, Paskowitz, Tompkins (Maui), Fleming (Maui).

Dr. Burgess designated the alternates who were present from the Honolulu County Society to act as delegates.

*Time Limit:* Dr. Devereux moved that this session of the House of Delegates be adjourned between 9:45 and 10. The motion was seconded and passed.

*Minutes:* Dr. Fleming moved that the minutes of January 22, 1954 House of Delegates meeting be approved as circulated. This motion was seconded and passed.

*Centennial Celebration Committee:* Dr. Richert suggested adding the name of Dr. Frank Pleadwell as a source member of the committee. This suggestion was approved.

The action of the Council on May 12 concerning the centennial celebration committee was approved on motion of Dr. Bell, seconded by Dr. Burgess.

The House of Delegates designated the following members to serve on the centennial celebration committee:

1. Harry L. Arnold, Sr., *Chairman*
2. Paul Withington
3. Fred Lam, Sr.
4. Louis Gaspar
5. Richard K. C. Lee
6. R. K. Uyeno
7. Walter B. Quisenberry
8. Kyuro Okazaki
9. R. B. Faus
10. R. C. Durant
11. John M. Felix
12. Toru Nishigaya
13. President
14. Immediate Past-President
15. President-Elect

ex-officio, voting members

(but do not count in quorum)

SOURCE MEMBERS

16. I. Katsuki
17. Fred Irwin
18. William Dunn
19. H. M. Patterson
20. Mrs. Robert Katsuki
21. Mary Catton
22. Helen Pratt
23. Dr. Walter C. Alvarez
24. Dr. George F. Straub
25. Dr. Ralph S. Kuykendall
26. Gwenfread Allen
27. Professor Porteus
28. Dr. William B. Meister
29. Dr. J. M. Kuhns
30. Dr. L. L. Sexton
31. Dr. Homer Hayes
32. Dr. Eric Fennel
33. Dr. Frank Putman
34. Dr. Frank Pleadwell

The delegates approved a suggestion by Dr. Richert that the committee be directed to send minutes of all its meetings to the respective county secretaries.

**ACTION: Dr. Marnie moved that the Delegates accept the committee membership and responsibilities as outlined and grant the president the prerogative to appoint any alternate members to the committee as necessary. The motion was seconded by Dr. deHay and passed.**

The functions of this committee shall be as follows:

1. That this special committee be known as the Centennial Celebration Committee;
2. That its term of office be effective from the date of its appointment in May 1954 to December 31, 1956;
3. That the committee's duties be:
   (a) To develop plans for the Centennial Celebration in 1956;
   (b) To prepare an appropriate scientific and social program for the annual convention in 1956;
   (c) To develop an historical review of medicine in Hawaii during the past century and to promulgate this information via press, radio, or television or any other media deemed advisable at such times as the committee may desire;
   (d) To seek assistance from any source the committee deems necessary. In this regard the chairman is authorized to appoint such subcommittees as he may require to carry out the duties of the committee.
4. That the committee be allotted $5,000.00 from the association treasury to carry out its functions;
5. That the committee submit timely reports to the President and progress reports at each meeting of the House of Delegates.

*Kaiser Health Plan:* Dr. Dodge, chairman of the Industrial Relations committee, outlined to the delegates the proposals of Mr. Henry Kaiser for introduction of a new health plan for Hawaii. Dr. Bachman, Dr. deHay and Dr. Gilbert, who had all worked for the Kaiser Foundation on the mainland, gave their impressions of it, which were, on the whole, favorable. Dr. Izumi pointed out that there are additional fees for maternity care, tonsillectomy, drugs, etc. under the Kaiser plan, so that it is not completely prepaid as subscribers are led to think. Dr. Yee also mentioned that persons who have reached the age of 60 are not permitted to join the plan. Dr. Lowrey added that the plan will not care for indigents or medical indigents.

Dr. Ito, Dr. Bachman, and Dr. Choy told of Mr. Kaiser's meeting with the executive committee of Kapiolani Hospital and his proposal to use its old building.

Dr. Pinkerton asked that everyone consider the effect on all other hospitals in Honolulu if the Kaiser plan were introduced in Kapiolani.

It was agreed that this discussion would be continued at 8 o'clock the following morning, and that Dr. Durnin of Long Beach, California, would be invited to tell of their doctors' experience with the Kaiser Foundation.

The meeting was adjourned to 8 a.m. the following day.

SAMUEL L. YEE, M.D.
*Secretary*

**Friday, May 14, 1954 at 8:00 a.m.**
**Mabel Smyth Building**

*Present:* Dr. Chung-Hoon presided. Among the members of the Association present were the following delegates and alternates: Drs. Larsen, Burgess, McArthur (Maui), Yee, Richert, Woo (Hawaii), Kushi (Maui), Bailey, Choy, Ito, Gebauer, Cushnie, Wiig, Devereux, Lowrey, Gilbert, Nelson, Paskowitz, Bachman, Morgan, Quisenberry, Stevens, Cockett (Kauai), Tompkins (Maui) and Fleming (Maui).

*Pacific War Memorial:* The following resolution was adopted on motion of Dr. Devereux, duly seconded:

**WHEREAS, The Pacific War Memorial Commission was established by act of the Hawaiian Legislature to create and maintain in Hawaii a living Memorial to our nation's and our allies' heroic war dead of the Pacific Ocean areas so that man's yearning for and efforts toward a peaceful world may be eternally held aloft and carried forward; and**

**WHEREAS, A Pacific Memorial System for Hawaii, approved by the Hawaiian Legislature, has been promulgated among the peoples of the United States and of the world by the Pacific War Memorial Commission; and**

**WHEREAS, The said Memorial System includes, among other memorials, appropriate memorialization for the thousands of fallen heroes who are interred in the National Memorial Cemetery of the Pacific, and for the unidentified dead from the Pacific areas; and**

**WHEREAS, The Pacific War Memorial Commission has for many years labored to have the American Battle Monuments Commission establish its Pacific Memorial in Hawaii, to symbolize the patriotism, sacrifice, and dedication of America's war dead in the Pacific Ocean areas; and**

**WHEREAS, The American Battle Monuments Commission has publicly announced its intention to construct in Hawaii such Pacific Memorials; we do hereby approve and adopt the joint plans of the**

**American Bottle Monuments Commission ond the Pocific War Memoriol Commission for o Pacific Memoriol in Hawaii in, neor, or in relotion to the site and spirit of Puowaino, the Hill of Socrifice—The Notionol Memoriol Cemetery of the Pocific, ond**

**We do hereby further pledge to the Americon Bottle Monuments Commission ond to the Pocific Wor Memoriol Commission our unquolified support ond opprobotion of the joint endeovor creoting the Pocific Memoriol in Howoii, to symbolize mon's unyielding struggle for ond toword the light of Eternol Peoce.**

*Osteopathic Problem:* The A.M.A. has recently considered broadening its attitude toward osteopathy.

**ACTION: On motion of Dr. Yee, seconded by Dr. Burgess, the delegotes recommended that action regarding osteopathy be left to the discretion of the delegote to the A.M.A.**

*V.A. Medical Care:* The chairman briefly summarized the past action of the A.M.A. regarding medical care of veterans and the proposed plan of the Tennessee State Medical Association. Dr. Cockett reported that Kauai favored the Tennessee Plan.

**ACTION: Dr. Devereux moved thot our delegote to the A.M.A. might use his discretion in the problem of VA medicol care (with the possible suggestion thot he might fovor the Tennessee plon). The motion was seconded by Dr. Burgess ond possed with two opposing votes.**

*Kaiser Health Plan:* Dr. William Durnin, president of the Long Beach County Medical Society, spoke of experiences with the Kaiser health plan in California. On the whole, his society was not favorable to the plan. He also mentioned that his county medical society had drawn up an average fee schedule which was adopted for use as a guide. They also have a committee which meets with representatives of management and labor and insurance plans. Much discussion followed. Dr. Lowrey made the following motion, which was seconded by Dr. Richert and passed.

**ACTION: In view of the fact thot members of the Howaii Medical Associotion ore olreody coring for medicolly indigent potients free of chorge ond hove olreody in operation o locolly sponsored ond operoted group prepoyment medical plon which, by its growth ond increosing benefit to members oppeors to be fulfilling the needs of the community, the House of Delegotes recommends thot the membership continue to support the Howaii Medicol Service Associotion plon.**

**ACTION: A motion by Dr. Poskowitz, seconded by Dr. Fleming, that o speciol committee be estoblished to investigote o plon to compete with the Koiser plon, wos tobled on motion of Dr. Bell, seconded by Dr. Burgess.**

**ACTION: Dr. Lorsen moved thot the nine medicol odvisory committee members of HMSA be empowered by this body to study oll plans for medicol core ond propose o plon to be submitted to this body. The motion wos seconded ond possed.**

*Joint Fee for Joint Service:* The Iowa State Medical Society is proposing a revision of the Principles of Ethics of the American Medical Association regarding joint billing of a patient treated by two or more physicians.

**ACTION: Dr. Devereux moved thot the A.M.A. delegote should use his own judgment regarding the Iowo resolution on joint fee for joint service. The motion wos seconded by Dr. Cushnie ond possed.**

*Fluoridation:* The chairman said that the County Medical Societies had approved of fluoridation of water but it has never been considered by the Territorial Association.

**ACTION: On motion of Dr. Richert, with only one dissenting vote, the delegates approved the fluoridation of woter.**

*Annual Meeting:* The dates of April 28 to May 1 were proposed for the 1955 annual meeting because it would be impossible for Dr. Lauren Ackerman, next year's postgraduate speaker, to come later in May. Dr. Larsen said he regretted it would be impossible for him to be in Honolulu at that time.

**ACTION: On motion of Dr. Burgess, seconded by Dr. Bell, it wos ogreed to hold the onnuol meeting in Honolulu April 28 to May 1, 1955 with o registration fee of $10.***

*Council:* The actions taken by the Council at its May 12 meeting were reported to the delegates.

**ACTION: On motion of Dr. Devereux, seconded by Dr. Bell, the Council report was approved and occepted.**

*Annual Reports:* All annual reports of officers, county societies and committees had been mimeographed and circulated to the delegates in advance. They were presented at this time and the recommendations were considered.

**ACTION: The recommendations of the Concer Committee were approved ond the report accepted on motion of Dr. Cushnie, seconded by Dr. Bell.**

**ACTION: Dr. Devereux moved that Dr. Isoac Kawosaki be designated to serve as a full member of the Emergency Medicol Service Committee in ploce of Dr. Steele Stewart. The motion wos seconded and carried.**

**ACTION: On motion of Dr. Burgess, seconded by Dr. Tompkins, the delegotes approved the first recommendotion in the Industriol Relotions Committee Report os follows:**

**In view of the imminent future borgaining between potentiol medicol plan consumers ond insurance orgonizotions, the medical profession should be constontly owore of its position, ond conduct its action for the best interest of oll concerned.**

**ACTION: Dr. Burgess moved to delete the second recommendation of this report os follows:**

**This committee should continue contact with those individuals neorest to o potential Permanente Hospitol ond Medicol Plon, as this will have strong repercussions throughout the Territory, should it be initioted.**

**This motion was seconded by Dr. Cushnie ond possed.**

The great need for some liaison between the Industrial Relations Committee and the Medical Advisory Committee of HMSA was brought out.

**ACTION: On motion of Dr. Choy, duly seconded ond possed, the delegates accepted the first part of recommendotion 3, "That this committee be retained in nome, scope ond objectivity," but deleted the bolance of thot recommendotion, "without formol relotionship with other committees or organizotions. By doing so, the medical ossociation mointoins on unbiased group of physicians who will be oble to reoct occordingly when contracts of consideroble importance to medicine ore negotioted."**

**ACTION: Dr. Richert moved thot the report be occepted with these deletions ond that the committee be so informed.**

**ACTION: On motion of Dr. Choy, seconded by Dr. Cockett, the first recommendotion contained in the report of the Advisory Committee to Bureou of Crippled Children wos approved. The second recommendotion in this report wos approved on motion of Dr. Cushnie.**

**ACTION: Dr. Devereux moved approvol of the recommendations mode by the Advisory Committee to the Bureau of Moternol ond Child Health. The motion wos seconded ond possed.**

* The date has since been changed to May 5-8, 1955.

**ACTION: On motion of Dr. Devereux, the delegates opproved the recommendotion of the Advisory Committee to the Territoriol Womon's Auxiliory.**

*Election:* Dr. Clarence E. Fronk was nominated for President-elect by the Nominating Committee.

**ACTION: Dr. Yee moved the nominotions be closed ond the secretory be instructed to cost o unonimous ballot for Dr. Fronk os President-elect. This wos seconded ond passed.**

The Nominating Committee had nominated Dr. L. A. R. Gaspar and Dr. A. S. Hartwell as Councillors for 3 years. Dr. William Walsh was nominated from the floor.

**ACTION: The nominotions were closed on motion of Dr. Choy. By written bollot, Dr. Gaspor ond Dr. Hortwell were elected to the Council.**

*Dr. Chung-Hoon:* Dr. Devereux said that all members of the Hawaii Medical Association had been very proud and happy to be associated with Dr. Chung-Hoon as President during the past 12 months. Dr. Ito spoke of his gratitude for the great cooperation which he received from Dr. Chung-Hoon while Dr. Ito was President of the Honolulu County Medical Society.

**ACTION: On motion of Dr. Devereux, seconded by Dr. Ito, the sincere appreciotion of the Howoii Medicol Associotion wos extended to Dr. Edwin K. Chung-Hoon for his outstonding leodership ond for his contribution to the heolth ond welfore of the Territory during his term os President of the Howoii Medicol Association. The motion wos possed unonimously.**

*Adjournment:* There being no further business, the meeting was adjourned at 11:10 a.m.

SAMUEL L. YEE, M.D.
*Secretary*

## REPORT OF THE SECRETARY

**Somuel L. Yee, M.D.**

The total membership of the Association in all classes is 521, of which 402 (22 more than last year) are paid regular members. By counties this membership is made up as follows:

| | *Regular* | *Associate* | *Retired* | *Life* | *Military Service* | *Honorary* | *Total, All Classes* |
|---|---|---|---|---|---|---|---|
| Hawaii | 43 | .... | .... | .... | 2 | 1 | 46 |
| Honolulu | 322* | 72 | 4 | 8 | 15 | 11 | 432 |
| Kauai | 12 | .... | .... | .... | 2 | 1 | 15 |
| Maui | 26 | .... | .... | .... | .... | 2 | 28 |
| | 403 | 72 | 4 | 8 | 19 | 15 | 521 |

* One member exempt from dues.

The total number of physicians licensed to practice medicine in the Territory of Hawaii as of March 31, 1954 is 636. Of this number 463 are now residing in the Territory. Of these 428, or approximately 94.6 per cent, belong to the Hawaii Medical Association.

We have 398 active members of the American Medical Association and 72 associate members.

## REPORT OF THE TREASURER

**T. H. Richert, M.D.**

Those who wish to check a more itemized report of our past operations and proposed budget will find these on file in the Medical Association office.

Messrs. Leman and Hough have audited our books for the past two years. We have found their services very helpful and we recommend that they be employed as our auditors for the coming year.

| INCOME | *1953-1954* | *Budget 1954-1955* |
|---|---|---|
| Dues | $ 9,500.00 | $10,050.00 |
| Journal Advertising | 11,271.70 | 11,600.00 |
| Journal Subscription | 2,592.95 | 2,700.00 |
| Annual Meeting | 1,952.25 | 2,500.00 |
| Interest | 47.60 | 50.00 |
| Miscellaneous | 164.75 | 165.00 |
| | $25,529.25 | $27,065.00 |
| EXPENSES | | |
| Journal Costs | $11,329.19 | $12,000.00 |
| Audit | 85.00 | 85.00 |
| Postage | 252.29 | 260.00 |
| Rent | 1,088.00 | 1,128.00 |
| Salaries | 8,100.00 | 9,225.00 |
| Supplies | 233.20 | 300.00 |
| Taxes | 73.55 | 275.00 |
| Telephone & Telegraph | 227.13 | 275.00 |
| Travel | 31.00 | 200.00 |
| AMA Convention | 2,475.88 | 1,975.00* |
| Medical Library | 100.00 | 100.00 |
| Miscellaneous | 228.72 | 250.00 |
| | $24,223.96 | $26,073.00 |
| Centennial Celebration | | 2,500.00 |
| | | $28,573.00 |

* Includes first class travel for both conventions, refunds to be made if tourist class is used.

## AMA POST-CONVENTION TOUR TO HAWAII

**June 26 to July 3, 1954**

**Walter B. Quisenberry, M.D.**

A steering committee has been working for several months on an AMA Post-Convention Tour to Hawaii, and our plans are quite definite now. Locally, this meeting will be considered the summer meeting of the Hawaii Medical Association.

At the present time, we have reason to expect that at least 300 mainland doctors and their wives (making a total of 600) will take advantage of this Post-AMA Tour. The airlines are providing transportation for about this number, and we understand hotel reservations are also being made for these guests.

## COMMITTEE REPORTS

### American Medical Education Foundation Committee

**Min Hin Li, M.D., Chairman**

Through the leadership of Dr. Ito of the Honolulu County Medical Society, a committee whose chairman is Dr. Charlotte Florine and whose members are Dr. Caroline Dizon Wong, Dr. Sylvia Haven, and Dr. Dorothy Kemp, individual approaches have been made, according to graduates of schools in certain regions, and foreign countries. This plan can be set as a pattern henceforth.

Since smaller contributions are urged, but to be given annually, a perpetual gift plan will eventuate.

Therefore, with the drive being more active now, and with better reports from the Foundation itself, it is sincerely hoped that this drive should be continued for the benefit of medical education.

### Board of Management Mabel L. Smyth Memorial Building

**V. C. Waite, M.D., Chairman**

Over the past two or three years there has been a gradual reduction in income, and during the past year, losses have amounted to about $300 per month. This has necessitated the sale of several bonds held by the building which represented an accumulation of excess profits obtained in past years.

It was felt that the building was being maintained at minimal cost. The possibility of additional income was explored, and it was felt that inhabiting agencies should be expected to pay rent comparable to charges made for similar space in similar buildings in the community.

Further studies revealed the alarming fact that the largest space occupant, the medical library, paid no rent. Altogether this appeared to the Board as a completely unrealistic situation. Accordingly a reasonable rate of rental increase was requested of all building occupants.

At about this time it was suddenly brought to the attention of the Board that no depreciation fund for the replacement of worn out furniture and fixtures had been established. Accordingly an entire new budget which included rental increases from the occupants of the building, a rental charge for the library, and fixed depreciation expenses, was prepared and agreed upon by the Board of Management in December, 1953.

The Honolulu County Medical Society, Hawaii Medical Association and Hawaii Nurses Association agreed to an increase in rentals. However, the task of obtaining rent from the library appeared an insurmountable problem inasmuch as their budget was obtained almost exclusively from the Honolulu County Medical Society and this figure was already considerably higher than the Medical Society wished to pay.

Furthermore, responsibility for operation of the library could not be placed upon the Honolulu County Medical Society since the library itself was an incorporated institution. Quite recently an investigation by the Library Board has disclosed that donations originally given to Mabel Smyth Building for the establishment of a library inferred that the library would be housed in the building and be free from paying rent.

In the meantime the building continues to lose money in an actual sense and still no provisions have been made for the replacement of worn out or wearing out furniture and fixtures.

In spite of these difficulties and the meager sources of income, it was possible during the year 1953 to repaint the exterior of the building. Several estimates for the work were obtained and we believe it was accomplished well at a reasonable price. During the year 1953, Dr. Nils P. Larsen, Dr. Ralph Cloward and Dr. Liljestrand all gave travelogues, the income of which was used for the benefit of the Mabel Smyth Building. These moneys were earmarked for the improvement of motion picture projectors and screen facilities. Several minor repairs were made on the interior fixtures and some new improvements were established in the office of the Honolulu County Medical Society after their institution of a new division.

The present members of the Mabel Smyth Board of Management are as follows: Dr. V. C. Waite, chairman; Mrs. Elaine P. Johnson, secretary; Dr. Richard C. Durant, representing the Hawaii Medical Association; Mrs. Lois D. Bell, representing the Hawaii Nurses Association; and Mr. A. L. Y. Ward, representing the Queen's Hospital.

## Cancer Committee

**I. L. Tilden, M.D., Chairman**

The Cancer Committee has held two meetings during the year and has worked closely with the Hawaii Cancer Society and the Territorial Department of Health. Actually there is relatively little that this committee can do other than cooperate with and guide the efforts of the Hawaii Cancer Society. This report, therefore, is in large part a report of the activities of the Cancer Society.

Dr. Ian MacDonald was brought to Hawaii by the Cancer Society in the spring of 1953, and was the main speaker at the 1953 annual meeting of the Territorial Medical Association on Maui. He gave ten medical lectures on Oahu and one to each of the county societies on the neighbor islands. Tumor clinics have continued to function at Queen's, St. Francis and Kuakini hospitals.

The cytologic laboratory of the Cancer Society has continued to function efficiently under the technical supervision of Mrs. Esther Chinn and Mrs. Jean Nishimura. A committee of five physicians under the chairmanship of Dr. Frank Spencer examines all smears which contain abnormal cells. It is of interest that over 30 cases of early, unsuspected carcinoma of the cervix have been discovered since the inception of this laboratory service.

The committee previewed several educational films on cancer, and cooperated in securing medical speakers for a number of meetings.

The cancer morbidity study conducted jointly by the Hawaii Medical Association, the Territorial Department of Health and the Hawaii Cancer Society continued during the year. A comparative study of the mortality from gastric cancer was completed by Mr. Ted Rhea of the Cancer Society and was published in the November-December 1953 issue of the HAWAII MEDICAL JOURNAL.

The research committee of the Cancer Society under the chairmanship of Dr. Harold Civin has been most active, and has a number of projects in mind. These projects were studied by Dr. Harold F. Dorn, chief biometrician of the National Institute of Health, in April, 1954.

The research committee has prepared a tentative outline of projects which might be carried out here if funds become available. These projects fall into three groups, experimental, pathological, and epidemiological. The latter seem to be most feasible at the present time. It is contemplated that information will be obtained from patients with cancer and from a control group by means of a carefully prepared questionnaire. The information requested will, of course, differ somewhat with the type of cancer under investigation. These interviews will be conducted by a carefully selected person, possibly a trained social service worker, and will only be carried out with the knowledge and consent of the attending physician. No project of this sort could possibly be successful without the backing of the medical profession, and approval in principle of such studies is therefore requested.

*Recommendations*

1. That the Hawaii Medical Association approve in principle epidemiological studies of the sort outlined above.

2. That the physician representing the local chapter of the Hawaii Cancer Society on the islands of Hawaii, Maui and Kauai also be appointed to serve as the local representative of the Cancer Committee of the Hawaii Medical Association.

3. That the Hawaii Medical Association continue to cooperate with and guide the efforts of the Hawaii Cancer Society.

## Emergency Medical Service Committee

**Robert B. Faus, M.D., Chairman**

During the past year the following officers have reported for active duty:

1st Lt. Sheldon Cholst
Capt. C. A. Domzalski, Jr.
1st Lt. Edward T. Emura
Lt. Edward C. Wo Lum
Major Richard Noda
1st Lt. Frank Joseph Sykes
Major Harry K. Takenaka
1st Lt. Stanley S. K. Wong

Released from active duty during the year were the following:

Dr. Edwin B. Adams
Dr. Richard E. Ando
Dr. Kwai Sung Chang
Dr. Clifford T. Druecker
Dr. Yasuyuki Fukushima
Dr. Andrew C. Ivy, Jr.
Dr. Kikuo Kuramoto
Dr. Joseph T. Lucas, Jr.

Dr. Donald G. Rumer
Dr. Ernesto Santos
Dr. William B. Simpson
Dr. Francis K. H. Won
Dr. Richard Y. K. Wong

We have carefully processed all physicians entering the service in order that they might be called in proper order. We have tried to welcome the doctors on their return, offering them assistance in finding or re-establishing a practice.

Since there have been no calls from Selective Service for physicians since last summer, the committee did not meet until March, 1954, nor did we ask for deferments. We have corresponded with neighbor islands regarding doctors in their jurisdiction.

We have recently been advised that very soon physicians will again be called to active duty through Selective Service and through the Reserve.

Only one physician has refused to enter the service. He was a Canadian citizen, but renounced his application for U. S. citizenship in order that he might leave our country.

At our request the Selective Service System in Washington, D. C., authorized its local office to purchase for us a Key Sort System with which we are recording and maintaining a complete file of all physicians in Hawaii.

Dr. West and Dr. Quisenberry represented Hawaii at the June, 1953 meeting in New York City of the Medical Advisory Board of the Selective Service Department.

The chairman has participated in all civil defense exercises from Eversharp 1 through 5. Most of them have been high level command post exercises.

The arrival of certain amounts of medical supplies, the Territory's appropriation of $250,000 and an additional $250,000 from federal funds, have enabled us to stockpile 20 one thousand casualty units of supply, which consist of drugs, dressings, instruments, blood substitutes and donor sets. In addition, the federal government has provided an additional 10 one thousand units of similar supplies for federal stockpiling in Hawaii. These would be available to any area in the Pacific where the federal government might direct their use. Antibiotics subject to deterioration are constantly kept fresh by rotation. This is all under the direction of the Board of Health. Dr. Richard K. C. Lee has designated Dr. Jerome Rosengard to sort out and stockpile properly these vast supplies with a locator file at three different areas; Board of Health, Civil Defense headquarters, and at the tunnel itself. There is a constant inventory maintained of all materiel.

The Blood Bank reports that its emergency unit is ready for immediate operation at the turn of a switch. More than 100 individuals on the Island of Oahu and 54 on the neighbor islands have been trained by the Blood Bank in connection with concentrated Civil Defense plans.

Governor Val Peterson, Federal Civil Defense Agency Administrator, was kind enough to appear before this committee on March 30, 1954 at our invitation. He graphically presented the possibilities of thermonuclear destruction which might be estimated in millions of kilo ton units. It thus becomes apparent that a committee such as ours should continue its function with renewed zeal and effort. In view of President Eisenhower's warning to the nation that we will continue to remain in jeopardy of attack for some time, it behooves us to strengthen our preparedness program by training and exercises in order that any plan for evacuation of areas or the care of casualties in event of disaster, either natural or man-made, might be orderly and proficient.

We are presently revising assignments and bringing them up to date in order that every physician may be summoned to his respective point of duty to function in the capacity in which he is best trained to serve. We urge your immediate attention to these assignments when circulated. If any correction or change is necessary, consult promptly with the medical director of the Hospital. Doctors assigned to aid stations should confer immediately with Dr. Mossman or his personnel officer for any change or reassignment.

We are glad to serve the Medical Society in this difficult capacity and are willing to continue the purposes and functions of this committee if you so desire. We would recommend that Dr. Isaac Kawasaki, our first alternate, be designated by the Association as a full member of the committee, replacing Dr. Steele Stewart who is no longer a member of the Medical Society.

## Hawaii Medical Journal

**Harry L. Arnold, Jr., M.D., Editor**

The last 6 consecutive issues of the Journal have averaged 82 pages each, exclusive of outside covers, which is a little larger than last year. These have been apportioned, on the average, as follows: advertising, 38; original articles, 15; features, 21; and nurses' section, 8. The ratio of text to advertising pages was 44:38.

Despite this relatively generous program, in terms of both size and page use, the financial picture is bright; we even broke last year's record.

| INCOME | *1952-53* | *1953-54* |
|---|---|---|
| Gross Advertising Receipts | $11,300 | $13,600 |
| Subscriptions and Sales | 2,200 | 2,600 |
| Total | $13,500 | $16,200 |
| EXPENSES | | |
| Commissions and Discounts | $ 1,700 | $ 2,300 |
| Printing and Postage | 10,000 | 11,300 |
| Total | $11,700 | $13,600 |
| Net Profit, Cash, for Year | $ 1,800 | $ 2,600 |

The successful performance is owing entirely to Mrs. Bennett's good management of the Journal, including the campaign for local advertisements started a year and a half ago.

We would like to have expressions of medical opinion, on either technical or non-technical matters, come from a wider spread of sources within the Association than is now the case. Editorials, signed or unsigned, would be welcome, and are solicited; correspondence on subjects of general interest would be welcome, and is solicited; comments and criticisms on the Journal itself are invited. It is about time, too, that an Assistant Editor be found and worked into the job of editing manuscripts and reports and preparing them for publication. Candidates for this job—it doesn't pay very much, but it's fun—are urged to inquire within.

In summary, we think the Journal is still improving slowly in size, appearance, content, prestige, and financial health, and we recommend its continued publication on the same basis as heretofore.

## Health Education Committee

**Katherine J. Edgar, M.D., Chairman**

This committee has devoted its energy to ways and means of developing TV programs. The following doctors have served on this committee: Katherine J. Edgar, Chairman; Herbert Chinn, Charlotte Florine, Fred I. Gilbert, and Wayne W. Wong.

Miss Jeanne Paty, Director of Health Education of the Department of Health, agreed to advise the committee.

The program director of KGMB-TV expressed great

interest in a health education program on accident prevention.

In January, Safety Month, an AMA 5-minute film "The Home Medicine Cabinet" was incorporated into a live show, using local people. Dr. E. K. Chung-Hoon was narrator.

In February, Heart Month, a program on rheumatic heart disease was given, incorporating an 11-minute film showing symptoms, diagnosis and treatment of rheumatic fever in childhood. Dr. Clifford Kobayashi was the narrator. Again the response was in general, favorable.

## Industrial Relations Committee

**Richard S. Dodge, M.D., Chairman**

The Territorial Industrial Relations Committee during the year 1953-1954 was composed of the following members: Dr. Douglas B. Bell, Dr. Thomas W. Cowan, Dr. Richard S. Dodge, Dr. Clarence E. Fronk, Dr. Frederick L. Giles, Dr. A. Leslie Vasconcellos, Dr. Samuel L. Yee.

The Committee has convened as often as considered necessary in order to discuss problems pertinent to "labor—insurance companies—medical profession" relationships. This apparently has been a year of trial and accumulation of data by insurance companies following inauguration of medical plans during the past two years.

The New York Life Insurance plan, the United States Life Insurance plan, Mutual of Omaha plan, and the Hawaii Medical Service Association are the main coverage organizations in the Territory at the present time. There bids fair to be considerable discussions between the larger companies in the future in an effort to increase their coverage and number of individual policyholders.

The Hawaii Medical Service Association has assumed the responsibility of circulating information pertinent to contractual medical plans, and national trends and opinions regarding the nation's health. It is encouraged to continue this publication as a logical part of their staff operation. As far as this Committee has been able to determine, at the present time, there apparently is no definitive plan to organize a Permanente Hospital and Medical Program in the Territory. This opinion is based on direct discussions with representatives of the organization most interested in this type of medicine. The following recommendations are presented to the members of the House of Delegates of the Territorial Medical Association:

1. In view of the imminent future bargaining between potential medical plan consumers and insurance organizations, the medical profession should be constantly aware of its position, and conduct its action for the best interest of all concerned.*
2. This Committee should continue contact with those individuals nearest to a potential Permanente Hospital and Medical Plan, as this will have strong repercussions throughout the Territory, should it be initiated.
3. That this Committee be retained in name, scope and objectivity without formal relationship with other committees or organizations. By doing so, the medical association maintains an unbiased group of physicians who will be able to react accordingly when contracts of considerable importance to medicine are negotiated.

* See Delegates' Meeting, page 483.

## Legislative Committee

**B. Allen Richardson, M.D., Chairman**

The Legislative Committee met weekly during the 1953 Legislative session. The Legislative Committee of the Honolulu County Medical Society and the Territorial Medical Association met jointly.

The most important piece of medical legislation was House Bill 692, to allow free choice of physicians in Workmen's Compensation cases. The bill passed both houses but died by pocket veto.

## Postgraduate Committee

**Shoyei Yamauchi, M.D., Chairman**

The Territorial Postgraduate Committee chairman wrote to each of the neighboring island Medical Societies early in the year offering to continue the plan of sending specialists from Honolulu to neighbor island Medical Society meetings, to carry on postgraduate education.

Dr. R. O. Brown and Dr. Herbert Chinn led a symposium on urology at the Maui Society meeting on October 25. On January 23, Dr. George Henry and Captain Dudley King conducted a seminar on gastrointestinal x-rays for the Maui Society.

It is our recommendation that such a program be continued and expanded during the coming year if it meets with the approval of the neighbor island County Medical Societies.

## Public Service Committee

**C. C. McCorriston, M.D., Chairman**

The Public Service Committee of the Hawaii Medical Association consisted of the same members who made up the Honolulu County Medical Society's Committee with the addition of Dr. R. J. McArthur, of Wailuku, Maui.

The major work of the Public Service Committee during the year was done under the auspices of the Honolulu County Medical Society and consisted of the selection of an Executive Secretary, Mr. Richard Kennedy, for the Honolulu County Society. A Bureau of Medical Economics was also set up for the Honolulu County Medical Society, likewise headed by Mr. Kennedy. It is now in operation. Physicians in counties other than Honolulu are invited to refer their collection work on Oahu to the Bureau of Medical Economics of the Honolulu County Medical Society where prompt and courteous attention will be given and collection methods will be ethical. Medical credit information is also available through this office.

The yearly Public Service Committee-Press-Radio Relations dinner was held under the auspices of the Hawaii Medical Association Public Service Committee. The general consensus was that the over-all relations with the press and radio have decidedly improved, partially as a result of personal contacts made through these yearly meetings. Although no representatives from the press of the outside islands made an appearance at this meeting, they were invited. It is suggested that the press-radio dinners be continued on an annual basis.

# ADVISORY COMMITTEES

## Advisory Committee on Chronic Illness

**Shoyei Yamauchi, M.D., Chairman**

Although members of the Health Department have conferred with the chairman of this committee from time to time during the year, the committee held only one meeting. In February, 1954 Dr. Rosengard of the Health Department informed the Chronic Illness Committee that the sum of $500 had been made available through the Department toward the expenses of one doctor who might attend the National Conference on Care of the Long-term Patient, to be held March 18-20, 1954 in Chicago. The Committee carefully considered

the possibility of sending a representative to the Conference and came to the conclusion that the approved funds might better be used here for secretarial assistance and other needs of the Committee. Dr. R. K. C. Lee approved of this decision and informed the chairman that the funds would be available for this purpose.

The members of the Committee also agreed to make available assistance to the Oahu Health Council and the Honolulu Council of Social Agencies in their Conference on Problems of the Aging Population, to be held in Honolulu April 23 and 24, 1954.

Three members of the Committee were appointed co-chairmen of the Health Committee for this Conference and four other members of the Committee agreed to serve as members of the Committees on Security, Spiritual Resources, Education and Housing for this Conference.

## Heart Advisory Committee

**A. S. Hartwell, M.D., Chairman**

During 1953, the Heart Advisory Committee considered the following subjects: (1) Dispersion of facilities for studying congenital cardiac disease. The committee regretted the widespread diversification of facilities for studying congenital heart disease in Honolulu. Leahi, Queen's, Children's, Kuakini and St. Francis Hospitals all have some good equipment and personnel for studying congenital cardiac disease. The committee discussed the possibility of obtaining a large grant from the National Heart Institute and attempting to set up a cardiac catheterization center. It was the opinion of the members individually that there were an insufficient number of potential patients in the Territory to warrant this expense.

(2) X-ray survey. The Board of Health has conducted an x-ray survey for the discovery of tuberculosis, and a certain number of patients with heart disease are uncovered by this means. It was the feeling of the committee that this survey should continue, and that adequate follow-up of the patient might be implemented by polling the physicians in the Territory who would be willing to examine patients thought to have heart disease who do not have their own physicians.

(3) Cardiac clinics on outside islands. The cardiac clinics previously instigated by the Hawaii Heart Association were in general thought by the committee to be a good thing. It was suggested, however, that they also be sponsored by the Hawaii Medical Association, and each county medical society on the outside islands is to be contacted regarding this.

(4) Distribution of the "Heart Bulletin." The "Heart Bulletin" is published under the auspices of the American Heart Association, and it was felt that funds from the National Heart Institute might be used to supply hospitals and medical libraries in the Territory, but that the physicians in the Territory should be polled to see which ones would like to receive this bulletin. One free sample should be sent as an example.

(5) Panel on the cardiac in industry. It was the feeling of the committee that sometime in the future, perhaps 1955, there should be a panel on the cardiac in industry with industrial leaders, company nurses and company personnel heads taking part. Such a panel might take place at the time of the Annual Meeting in 1955.

(6) Anticoagulant programs. Funds are available from the National Heart Institute for training laboratory technicians in the determination of prothrombin levels in the blood. It was the opinion of the committee that rather than send someone from the Territory to the mainland for this purpose, the St. Francis or Queen's Laboratory might be compensated and be able to teach technicians locally.

The chairman wishes to thank Drs. John Bell, Walter Chung, Albert Ishii and William Walsh for their work as members of this committee.

## Radium Advisory Committee

**Philip S. Arthur, M.D., Chairman**

There were no formal meetings as such of the Radium Advisory Committee of the Hawaii Medical Association during the last year. An informal discussion was had with Mr. Schramm, Chief of the Bureau of Industrial Hygiene, regarding protection from radiation exposure. The recently purchased radium supply entails greater exposure both to the health department assistants as well as the physician and his assistants. Modification in arrangements for handling the radium and the type of carrying boxes were made by Mr. Schramm and these recommendations were submitted to the various doctors concerned.

The only recommendations suggested were again on an informal basis between Mr. Schramm and myself regarding the use of rubber filters for our present radium supply. We both feel that they are indicated and the subject will most likely be taken up formally in the near future.

## Advisory Committee to the Bureau of Crippled Children

**J. Warren White, M.D., Chairman**

As recommended by the House of Delegates at the annual meeting last year, we met in Honolulu on January 11 and two important matters were brought up for discussion and recommendations.

The Bureau of Crippled Children has carried on effectively as in the past and their detailed activity can be checked by reviewing their annual report.

At various other times, Dr. Connor has discussed informally with the Chairman of your committee minor matters such as the elimination of the usual three-month waiting period in a child severely burned where dire consequences would have developed and where public money was not immediately available.

Dr. J. P. Frazer presided at the January meeting in the absence of the chairman, Dr. J. Warren White, who was ill. Of the fourteen members of this Committee, ten members were present. Five members of the Health Department were present as well. Two important recommendations were made at this meeting.

The 1953 recommendations of the Committee to the Territorial Medical Association were considered. The recommendations were approved by all four county medical societies. However, a sentence was added to the recommendations regarding the uses of other community agencies for crippled children cases stating that this "was at the discretion of the Chief of the Bureau of Crippled Children." It was pointed out that the clause added by two of the medical societies giving the discretion to the Chief of the Bureau in deciding whether or not a child should be cared for by an available agency or by a private physician, actually left the Chief of the Bureau no policy on which to base a decision. The Committee voted unanimously to resubmit the following recommendation to the Territorial Medical Association:

**That medically indigent children on the Bureau of Crippled Children's Program not be given financial assistance from the Bureau for care on an individual private case basis unless there are no institutional facilities available to give that care.**

The second important recommendation made was as regards the establishment of Otological Diagnostic Clinics and it was recommended that "Otological Diagnostic Clinics be instituted in conjunction with the Public Schools' Hearing Testing Program on a demonstration basis, in such Counties of the Territory where the plan is approved by the local County Medical Societies."

## Advisory Committee to the Bureau of Maternal & Child Health

**Satoru Nishijima, M.D., Chairman**

Three meetings were held during the past year; one in Lihue, Kauai, one in Hilo, Hawaii, and one in Honolulu. It was regrettable that no meeting could be held on the island of Maui.

There were seven maternal deaths during 1953:

1. Ruptured ectopic pregnancy (2)
2. Brain tumor
3. Poliomyelitis
4. Pulmonary embolism
5. Eclampsia
6. Pulmonary edema—undetermined cause

A new program was instituted whereby meetings of this committee were to be held at 3 months intervals on the 4 major islands: Hawaii, Kauai, Oahu and Maui. This was done to improve maternal and neo-natal mortality studies and to lower infant and maternal mortality in the Territory.

Recommendation for the year 1954 is as follows:

That the Territorial Medical Association consult with the Department of Health and set up a new committee to consider the problem of day care centers in the Territory in respect to licensure and supervision which is the responsibility of the Bureau of Maternal and Child Health.

## Advisory Committee to the Territorial Woman's Auxiliary

**W. S. Ito, M.D., Chairman**

Although the Auxiliary did not call upon the Advisory Committee, there was an occasion to meet with Mrs. Garton Wall on February 9, 1954 at the meeting of the Committee on Arrangements. At this time the program of the annual meeting of the Auxiliary was made known to the group.

Recommendation:

That the president and president-elect of the Hawaii Medical Association automatically serve as the Advisory Committee to the Woman's Auxiliary.

## Woman's Auxiliary to the Hawaii Medical Association

**Mrs. Garton Wall, President**

The Woman's Auxiliary to the Hawaii Medical Association is concluding its sixth year of activity. We have a total paid membership of 219, made up of 162 from Honolulu County Auxiliary, 30 from Hawaii County, 22 from Maui County, and 5 Members-at-large from Kauai, where there is no County Auxiliary.

In September, letters were sent to the wives of all the doctors on Kauai, who were members in good standing of the Hawaii Medical Association, explaining to them that they could join the Auxiliary as Members-at-large. Four wives responded at this time, plus one more who has been a faithful supporter since our inception.

There have been four meetings during the year—two of the Executive Board, one of the House of Delegates, and the annual luncheon meeting for the general membership, held this year on Oahu, with Honolulu County as hostess.


*In very special cases*
*A very superior Brandy*




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# NOT ARTHRITIS BUT ARTHRALGIA...

If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.[1] It has been estimated that arthralgia occurs in about 40 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.[2] In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

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1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America *30*:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

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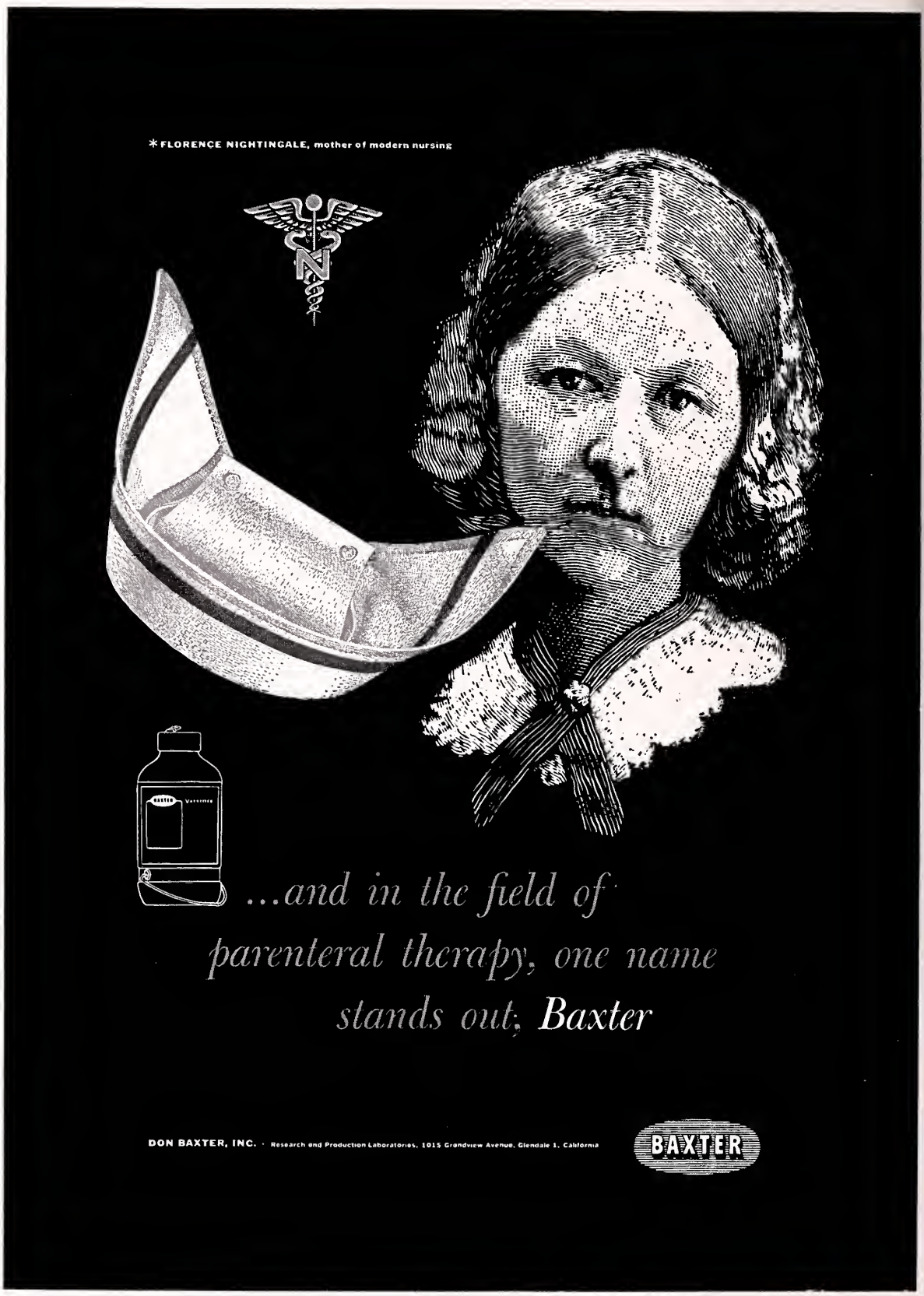
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# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

LEONA R. ADAM, *Executive Secretary*, Honolulu

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## NATH WORKSHOP ON ECONOMIC SECURITY

The Economic Security Workshop was held in the Mabel Smyth Building on April 2, 3, and 4, 1954. Thirty nurses representing all sections attended the full workshop, lectures, and group meetings. This included two from Hawaii, one from Maui, and one from Kauai.

Representation from sections was as follows:

| | | | |
|---|---|---|---|
| General Duty | 4 | Industrial | 3 |
| Private Duty | 1 | INSA† | 9 |
| EACT* | 6 | Special Groups | 3 |
| Public Health | 4 | | |

In addition to the above, nineteen nurses were present for one or more lectures.

The purpose of the workshop was to give section committee members the principles and essentials of a sound economic security program, and an understanding of how to set up functions, standards, qualifications, and minimum employment standards.

Miss Harriet Kuwamoto presented the history and development of the ANA economic security program.

Mr. Val Marciel, Territorial Budget Examiner, discussed community economy in relation to employee requests in an attempt to give some basis for consideration of what employers can afford to offer employees.

Mr. Charles Kendall, Director, Hawaiian Government Employees' Association, discussed "Considerations Basic to Establishment of Minimum Employment Standards." This was in relation to setting up functions, standards, and qualifications. Mr. Kendall has had much experience in this program and we were especially pleased to have him participate in this program as the Association will be working closely with him in relation to nurses employed by the Territorial government.

Mr. Tom Ige, Associate Professor of Economics and Business, University of Hawaii, and Mr. Richard Beaumont, Assistant Director of Research, Hawaii Employers Council, spoke on "Minimum Standards of Employment" and "Salary Study Methods."

On Sunday morning Mrs. Thelma Bourg, Classification Analyst of Tripler Hospital, discussed "The Development of Uniform Standards by Job Analysis and Comparison."

Each day there were one or two sessions during which the enrollees were divided into three groups for discussion of the material presented. Out of these groups evolved a summary of the workshop with some recommendations which were sent to all full time participants and to all section chairmen.

Two criteria for judging the success of this workshop are (1) attitudes, response and actual participation by members of the workshop, and (2) increased activity by section committees in the establishment of functions, standards, and qualifications, and in setting up minimum conditions of employment. According to the first criterion, the workshop was a huge success, as every-

* Educational Administrators, Consultants, and Teachers.
† Institutional Nursing Service Administrators.

one was enthusiastic and participated very actively. At the time of this writing, according to the second criterion, the workshop did not accomplish much as section activity still has not been stimulated! The Economic Security Committee will need to give this further thought.

The committee gave much time and thought to the organization of the workshop and we owe them a vote of thanks for a job well done. The informal coffee hours and the fine help from some of our so-called "inactive" nurses added much to the enjoyment of those attending.

Workshop Committee: Sister Mary Albert, Chairman; Mrs. Alice Scott, Lt. Col. Eileen Brady, Miss Harriet Kuwamoto, and Miss Leona R. Adam.

## ANA FINANCIAL REPORT

**March 1954**

Dear ANA Member:

This is your copy of the financial report filed with the U. S. Department of Labor in compliance with the Labor-Management Relations Act. Non-communistic affidavits from all ANA officers have been filed with the National Labor Relations Board.

*American Nurses' Association*
*Financial Statement*

January 1, 1953—December 31, 1953

| RECEIPTS | | DISBURSEMENTS | |
|---|---|---|---|
| (1) Dues | $846,891.50 | (1) Per capita tax, assessments, allowances | none |
| (2) Fees, fines, assessments | none | (2) Salaries | $248,391.30 |
| (3) Others | 8,425.30 | (3) Taxes, (Federal & State) | 7,557.52 |
| | | (4) Other: Program & office administration | 435,893.90 |
| | | Dues to other organizations | 20,299.29 |
| TOTAL | $855,316.80 | TOTAL | $712,142.01 |

(5) Total assets at end of fiscal year (cash, investments, property, etc.) ..... 297,810.44

(6) Total liabilities at end of fiscal year ..... 52,304.12

I, duly authorized official of the above-named association, certify that the information submitted herewith is true to the best of my knowledge and belief.

ANNABELLE PETERSEN, *Treasurer*

Nurses, through ANA, are building a sounder future for their profession. They are striving to improve their professional practice, to raise the economic status of nursing, and to assure best use of nursing skills and experience to meet the health needs of the American people.

This monumental task requires the effort of every nurse in this country.

ELIZABETH K. PORTER, R.N.
*President*

## FINDINGS AND PROGRESS OF ANA'S STUDIES OF NURSING FUNCTIONS CAN NOW BE EXAMINED AND CORRELATED AND SHOULD BE USED*

The time has come—it is now possible to begin examination of the findings and progress made in ANA's research program on studies of nursing functions. Those present when the program was authorized by the House of Delegates in 1950 will remember what an exciting moment that was in ANA experience. Persons outside of nursing have said this program is one of the most creative and enlightened undertakings ever initiated by any profession. It has taken time to outline the program and to adapt research tools to nursing's needs. But now with 8 studies published, 4 in progress and 5 approved in January, we can begin to correlate findings and use the data found.

The completed studies have covered 84 hospitals ranging in size from 25 beds to over 1,000 and including government, municipal, non-profit, proprietary and church institutions. All types of nursing service units, all shifts and a variety of nursing personnel have been studied. Most complete coverage of personnel is found in the Charles T. Miller Hospital Study, St. Paul, Minn., sponsored by the Minnesota SNA, and the Study of Nursing Functions sponsored by the Washington SNA.

Present data will be rounded out with the completion of the three studies now in progress: nursing services in surgical and medical wards of Charity Hospital, being conducted by Tulane University and sponsored by the Louisiana SNA; work of the general duty nurse in non-metropolitan general hospitals and the meaning of this work as seen through the eyes of the nurse herself, undertaken by the University of Missouri sponsored by the Missouri SNA; and the social-psychological characteristics of the student and graduate nurse which correlate with durable membership in the profession and factors which make for high or low morale, by the University of Pennsylvania for the Pennsylvania SNA.

The nurse has a traditional role of patient care but working as she does in a changing scene, she has acquired many new functions. These new functions are being confirmed by our studies. What part of the total will be called nursing and how far nursing can depart from its historic role is the question.

Research can't supply all the answers in a neat package. It is a tool for finding the facts and offering interpretations. Nurses themselves must apply the findings to their own practice.

* *ANA Guide Lines*, American Nurses' Association.

This can now be done in institutional nursing. We have the tools for time and motion studies. Nurses now can obtain from ANA's Research and Statistics Unit sample check lists of activities which can be used to compare and improve their own and their team's activities.

Space doesn't permit printing all the significant findings which are beginning to emerge. But an indication can be given.

On time spent by nursing personnel in non-technical tasks—"The two large hospitals with Housekeeping and Dietary Departments report nearly as much of a percentage (17 and 19) of the floor nursing time in these two areas as did the small non-departmentalized hospital (21 per cent). Nursing personnel time for the distribution and collection of food and water represents a little more than the full time of two people if based on a 40 hour week in Hospitals A and B"—Study of Nursing Functions in 12 Hospitals in the State of New York.

On nurses' activities—"The activities of these nurses represent a considerable diversity of duties. The nature of these activities changed every three minutes or 20 times an hour"—Pilot Study, The Functions of the Nurse in the General Hospital, Arkansas. (This change, every three minutes, was the same indicated in the Charles T. Miller Study.)

"Registered nurses in small Kansas hospitals are performing 482 different activities. These range from direct care of patients to firing the hospital furnace" — Activities of Registered Nurses in Small Kansas Hospitals.

Fifth most highly rated activity of staff nurses was "keeping patients' room tidy"—Role Relationships Among Nurses and Between Nurses and Non-Nursing Personnel in Hospitals, Alabama.

### Many Areas in Nursing Need Research Work

Most of the studies completed so far under the research program have been in the field of institutional nursing. This was a logical place to begin, but now we should expand into other fields.

Studies are needed beyond the observation of a nurse's job in the hospital. Actual experimentation with new patterns of work using the hospital ward as a unit should be undertaken. One step in this direction is the study for which funds were granted in January to Boston Psychopathic Hospital, a test with chronically ill mental patients of techniques and methods found successful in earlier studies, to be carried on at Massachusetts State Hospital.

We need research on opportunities for in-service programs in institutions. So far data on this subject have not emerged clearly. Early general duty questionnaires indicate a need for better in-service programs.

Nothing has been done so far on the work of the operating room nurse.

Studies are needed for all fields of nursing. For example, the new study, also approved in January, dealing with the private duty nurse sponsored by the Georgia SNA.

More data are needed about what nurses think they should be doing and what the public thinks a nurse's job is.

Another area which needs study is the doctor-nurse relationship.

## HEADQUARTERS NEWS

Do you need "scratch" paper? NATH office has considerable with mimeographing on one side, but quite usable. Come and get it.

✓ ✓ ✓

As this issue goes to press the delegates to the Biennial have not yet returned so no report is available.

The Executive Secretary was unable to attend either the three day ANA committee meeting for Boards for Licensing, or the Biennial, both held in Chicago, as the Governor did not approve the request of the Board for the Licensing of Nurses for mainland travel.

✓ ✓ ✓

The Executive Secretary was requested to attend a recent meeting of the Hospital Council of Honolulu to explain the Economic Security Program of the Nurses' Association. These administrators were intensely interested in the program and, on the whole, expressed approval of the program as presented.

✓ ✓ ✓

This office receives copies of the State Nurses Bulletins from many states. If anyone is interested in seeing any of them, come in—or let us know and we will send them to you.

## AN IDEAL DISTRICT

The following, adapted from a recipe presented at a national convention of the Zonta Club, tells how to have a successful district organization:

Take equal parts of desire for continued growth in service to your employer and patients and of desire for your economic security, and mix them with enough sociability to make a light sponge, and set aside to rise.

When this has risen to about twice its original bulk, add some carefully picked officers and directors, thoroughly dredged in the waters of self-

sacrifice and plentifully dredged with perseverance.

Take a whole heartful of enthusiasm and dilute it with a headful of common sense. When the alkali of the enthusiasm mixes with the acid of the common sense, stir it quickly into the mixture. Then add your spices—pep, tact, zeal, zest—a generous dash of each, not forgetting a pinch of difference of opinion to give it a tang.

Now take a dozen fresh committees (not too fresh) beaten until they are stiff enough to stand alone, and fold them in lightly. Add a few choice programs, neither too dry nor too long, as ample room must be left for them to swell with animated discussion. Lastly, add your flavoring. Browning's extract of optimism is very good; Emerson's may be used if preferred. Some like just a bit of Shakespeare for special occasions.

Now beat the whole up well with individual effort. Upon this absolutely success depends. When thoroughly beaten, pour into a large vessel of opportunity which has been previously well smeared with some good authority on parliamentary law to keep it from sticking. Then set in an attractive, well-ventilated clubroom for one and a half or two hours. The time will depend upon the temperament manifested. We guarantee the result will be satisfactory.

This, ladies, is the latest recipe on the Ideal District.

## NURSES' ASSOCIATION, COUNTY OF HAWAII

Members of the Nurses' Association, County of Hawaii, were honored to have as their guest speaker at one of their regular meetings Mrs. Allan Saunders of Honolulu.

Dr. Allan Saunders of the University of Hawaii, and Mrs. Saunders, visited Norway, Denmark, and Sweden in 1952 and while on their tour of these different countries, took colored slides of all the interesting places. These colorful slides were shown to us and were individually explained by Mrs. Saunders. All the members enjoyed the colorful slides and her visit with us.

✓ ✓ ✓

The city of Hilo was beautifully decorated on April 15 and the shores of Hilo's bay were crowded with curious people as well as with official representatives of the different organizations here to greet the British liner Caronia. Mrs. Hazel Flagg and Mrs. Mae Marcallino of the Nurses' Association, County of Hawaii, volunteered to lend their hearty kokua on this big day. First aid stations were set up at two different places in Hilo, with one nurse, to take charge of any casualties. The Hawaii Visitors Bureau and the American Red Cross, Hawaii Chapter, ask for kokua from the Nurses' Association, County of Hawaii, whenever any occasion, such as this one, is held in our city. The members are always ready and willing to lend their kokua whenever and wherever they are needed.

✓ ✓ ✓

Another big event which crowded our city here in Hilo was the Boy Scouts Makahiki held on May 8. Mrs. Hatsumi Ishikawa and Mrs. Sadako Doi of the Public Health Department volunteered to serve on this day.

✓ ✓ ✓

Miss Florence Alhime, Surgery Supervisor of Hilo Memorial Hospital, returned after a two months vacation visiting her family in Los Angeles. "The trip was wonderful to and from Los Angeles, but it was so good to come home to Hilo," she said.

✓ ✓ ✓

Miss Angela Goya of Hilo Memorial Hospital returned to work after a month vacation. She is a graduate of St. Francis Hospital School of Nursing and has done postgraduate work in surgery at Cook County Hospital in Chicago. She is a member of the surgical staff here in Hilo.

✓ ✓ ✓

Mrs. Emma Lau greeted her first son on April 20, 1954. She is a graduate of Queen's Hospital School of Nursing, class of 1948, and is with the Public Health Department in Hilo.

## MAUI DISTRICT NURSES' ASSOCIATION

The Maui District Nurses' Association sponsored a Poliomyelitis Workshop in March at the Central Maui Memorial Hospital. The need for this workshop was greatly realized by the members of the association because of the large number of active polio cases on Maui. The total today is 16 cases. The workshop was held at the conference room of the Central Maui Memorial Hospital with the following participants:

Dr. Elim Mei, Maui County Health Officer
Mrs. Miriam Schmidling, R.N.
Miss Miriam Hamasaki, R.N., R.P.T.
Miss Judie Sakamoto, R.N.
Mrs. Ruth Suzuki, R.N.

Dr. Mei discussed the scientific approaches toward polio, gamma globulin, polio vaccine, symptoms, laboratory findings and their interpretations, and isolation techniques required by the Board of Health.

Miss Judie Sakamoto and Mrs. Ruth Suzuki

demonstrated the nursing techniques during the acute stages.

Miss Miriam Hamasaki discussed the correlation of physical therapy procedures and follow-up treatments.

A bazaar was held in May as a money making project as suggested by Miss Jitsuko Watanabe, Chairman of the Finance Committee. Miss Masami Shiraki was in charge of the bazaar.

The industrial nurses met in April to form an Industrial Nurses Section of the Maui District Nurses' Association. Miss Eileen MacHenry, Chairman of the Industrial Nurses Section of NATH, presided. The following officers were elected:

Mrs. Marjorie Okinaka, Chairman
Mrs. Judith Magarifuji, Vice Chairman
Mrs. Wyoma Bradley, Secretary

Miss Judie Sakamoto has left Maui and is now employed at the Veterans Hospital in Santa Monica, California. She was a member of the Puunene Hospital nursing staff previous to her departure.

The Nurses' Association took active part in the observance of Business Education Day, held on April 27, 1954 and sponsored by the Maui Chamber of Commerce. The association treated three prospective nurse students from the three high schools on Maui to a tour of the Wailuku Sugar Company Dispensary and also the Central Maui Memorial Hospital. This was greatly appreciated by the students.

## NURSES' ASSOCIATION, DISTRICT OF OAHU

Agnes Saddler, Public Health Nurse, has gone to the Trust Territory to work with Miss Ruth Ingraham, R.N., Supervisor, in the training of local people in health teaching, care of the sick and midwifery.

Mrs. Helen Gage, long an active member of our Territorial and County Nurses' Association, left with her husband June 1 for Amman, Jordan.

Mr. Gage who is employed by the United States Government will establish hotel facilities in Amman and train personnel for various duties pertaining to operating hotels.

Just before leaving they completed a six-weeks orientation in Washington, D. C. This included a short course at Michigan State University Hotel School for Mr. Gage and a "short short" course in Arabic for Mrs. Gage.

On the way to Jordan, they will visit Rome, Athens, Cairo and Beirut.

Their address is: U. S. O. M. Jordan; c/o Department of State Mailroom; Washington 25, D. C.

All mail will have to have international postage.

## ALOHA

The Queen's Hospital welcomes Miss Rose Margaret DeWever, Director of Nursing and of the School of Nursing. Miss DeWever joins the Queen's staff after her recent experience as Nursing Coordinator for the Aramco Field Hospitals and Clinics in Saudi Arabia.

She graduated from the Missouri Baptist Hospital, following which she did hospital nursing. She received her B.A. from South East Missouri State Teachers College and M.A. in business administration from the University of Pennsylvania. Miss DeWever has taught at William and Mary and at the American International College in Saudi Arabia.

Nursing education and administration have always been the foremost interests of our new Director of Nursing; however, her avocations are many. She writes for publication, does some oil painting, enjoys semi-classical and popular music, and indulges keen interest in languages and literature.

## NEED FOR CAREFUL THOUGHT

What can we do here in the Territory for the nurse who is handicapped and the nurses who are growing older?

Nurses of 60 and 65, who are still interested in making a contribution to nursing and still in need of an income, are having difficulty finding positions. What can we do to help them find work within their capabilities?

Here is a nurse with a severe hearing defect. A hearing aid gives her assistance, but she still must see the face of the person addressing her, and she cannot use the phone. She has been out of nursing for five years, but now is in need of an income. She has considered other work possibilities, but all her background is nursing and she feels very strongly that she must remain in nursing. She plans to take the refresher course offered at Queen's—but where can she go from there?

Send your suggestions to the Counseling and Placement Service, Nurses' Association, Territory of Hawaii, Inc.

# NEW CONCEPTS OF INDUSTRIAL NURSING*

Mary Louise Brown†

Occupational health is an area of public health, the focal point of which is the occupation of individuals and groups. It utilizes a team with the professional skills of medicine, engineering, nursing, toxicology, health education and biostatistics to conserve and promote the health and effectiveness of individuals and groups at and through their place of employment.

The primary function of all health personnel in the field of Occupational Health is to improve and protect the health of each individual worker.

The duties of the industrial nurse as a member of the Occupational Health team will be shaped by the needs of the workers in her plant and by the special hazards of the industry. She may be one of many on a well rounded staff of professional and non-professional personnel. Here, the industrial nurse must be able to participate as an equal with the other specially prepared for optimum functioning of the team. In most cases she will be the only full-time professional person in the health service and must assume some of the duties of the other members of the team.

Industrial nursing is a comparatively new specialty of nursing and many of its early leaders are still active in the field. Ida Stewart is named as the first industrial nurse. She was employed by the far-sighted management of the Vermont Marble Company in 1895 to give home nursing service to the workers and their families. America's two world wars, the resulting man-power shortage, and the changes in social legislation exemplified by the enactment of Workmen's Compensation and Social Security set the stage for present day industrial nursing. These factors account for the rise in the industrial nurse census from 1 in 1895 to 871 in 1918 and to 3,200 in 1930. The present census of almost 12,000 nurses employed by industry is equal to the total number of graduate nurses who were actively employed in 1900.

During the earliest days there were nurses sufficiently capable and visionary to organize and carry out the type of industrial nursing service which clearly demonstrated the actual and potential values to be derived from an occupational health program. Their example was sufficiently outstanding to establish the prestige of the field and to make the industrial nurse the key member of the occupational health team. To these outstanding pioneers a great deal of credit is due. As the past has demonstrated, the future of industrial nursing depends on the nurse. The nurse's interest in the field, her personality and her preparation will determine the success and will shape the future of occupational health nursing.

As in any other field of health, it is possible to visualize new concepts in occupational health nursing only in the light of past and present philosophies of the personnel active in the field. I would like to suggest team-work and co-operation as one-word definitions of the two concepts that should be applied to the field of occupational health nursing. In reality neither is new, and their application to the field in the past accounts for the present high standard of performance; but universal acceptance and universal implementation of team-work and co-operation in their broadest sense would assure for the field and for the individual nurse the prestige and feeling of satisfaction that are inherent in this special area of nursing.

Both words have much in common and both appear often in the literature. We talk about them but we do not always live them. Let's think of team-work as the influence *within* the occupational health program and co-operation as the influence *beyond* the occupational health program.

The concept of team-work has as its base people who can work together, all equally well prepared, all equally interested in the field and all talking the same language.

The activities of the occupational health nurse are varied; team-work and co-operation must be an integral part of all that she does. Care of workers with occupational injuries and diseases has been and will continue to be one of her main duties. In 1950 there were almost 2 million injuries and 15,500 workers were killed as the result of industrial accidents.

Many nurses in occupational health carry on the treatment of the injured worker under remote control medical direction. The nurse must not permit herself to be placed in the vulnerable position of assuming too much responsibility. She must function within the realm of her medical standing orders. These must be written and signed. They cannot be written for universal adoption but must be worked out by both nurse and doctor. Standing procedures rather than standing orders give the nurse greater leeway. Only when her nursing procedures are combined with the doctor's standing orders can the doctor have an un-

* Speech presented at Thirteenth Annual Continuation Course for Industrial Nurses, University of Minnesota, Center for Continuation Study, Minneapolis, Minnesota, April 30, 1953. Reprinted from *What's New in Industrial Nursing*, v. 4, no. 8.

† Assistant Professor of Public Health (Occupational Health Nursing), Section of Occupational Health, Department of Public Health, Yale University, New Haven, Connecticut.

derstanding of what the nurse does and how she does it. This type of team-work, based on a frank evaluation of the role of both doctor and nurse, assures the worker proper treatment, the industry that its health program is professionally ethical, and the physician and nurse an ideal working relationship. This working relationship between doctor and nurse is intangible. It must be based on mutual respect and understanding, not only of the person, but on their separate abilities and preparation for their profession.

This same doctor-nurse team-relationship permits the nurse to participate actively in the physical examination program. She may be largely responsible for taking the health and work history and for the "follow-up" program.

The nurse's part in safety and plant housekeeping will usually be that of a consultant. Her understanding of personality, her interest in the workers of the plant and the wealth of information in her records can help to make both the safety and the plant housekeeping program more effective.

These activities of the occupational health nurse are only several out of many where a true team-work relationship is important.

Team-work does not just happen. It becomes a reality only *after* careful planning and long practice but when established it pays big dividends.

The second concept, co-operation, will be successful only if it is understood to mean a working together.

No one person or program can meet all the worker's health needs. An occupational health nurse must know her community and its health and welfare facilities. She must be able to help the workers of her plant to know of these and to use them. She must also help them to follow the advice and directions of their family doctors and dentists.

The occupational health nurse must have a genuine liking for people. She must find it a dynamic experience to work with people who are not patients. In occupational health the nurse finds the perfect setting for positive health. Here she discovers that helping people to stay well is just as fundamental as helping them to get well. This assumes major importance when we realize that there are 48 million workers in commerce and industry and with their dependents the total equals 100 million, or two-thirds of the population of America. The occupational health nurse is faced with the tremendous challenge of helping to make the World Health Organization's definition of health as "a state of complete physical, mental and social well being—not merely the absence of disease and infirmity" a reality for America's workers. She must assume responsibility, not only for helping the workers of her plant to use community health facilities, but also for helping these allied health agencies to use the occupational health program to the end that the workers and their families may maintain the highest possible level of health.

Team work and co-operation will demand more of the occupational health nurse. She will discover that her program is much more active, and that much more is required of her; but she will also discover, perhaps for the first time, that she is really fulfilling her primary responsibility, that of improving the health of each individual worker to the maximum extent possible within the framework of the program. Of equal importance, she will find her job interesting and rewarding.

## YOUR ECONOMIC SECURITY PROGRAM

*What it is*

A. It is an effort to improve working conditions for nurses:
   1. By developing realistic salary schedules.
   2. By obtaining a forty hour week.
   3. By securing a reasonable number of paid holidays.
   4. By obtaining an adequate annual vacation.
   5. By obtaining reasonable sick leave allowances.
   6. By building an insurance program for sickness and retirement.

B. It is an effort to develop permanent hospital group exploration and planning:
   1. For continuous improvement of the conditions of work (as above).
   2. For the improvement of patient care
      a. Better facilities
      b. Better organization
      c. Orientation and in service programs
      d. Clarification of duties.

   (Nurses realize that patient care is much larger than nursing care alone; nurses wish to sit with allied health groups to improve patient care.)

*How the Economic Security Program will work*

A. It will use NATH to spearhead local discussion and action groups, especially where problems exist.

B. It will use NATH to study and recommend realistic, just, conditions of work.

C. It will strive to stimulate permanent groups in the hospital that will discuss problems of patient care and plan for continuous improvement.

The recommended working conditions will be set up by the members of NATH within each section after (1) survey and study of existing employment conditions within each section, (2) consideration of conditions of employment of other comparable groups, and (3) careful review of the local cost of living index.

## NEW PUBLIC RELATIONS MATERIAL

We have recently purchased the following excellent materials from the National Publicity Council which are available to you in the Adams Library in the Mabel Smyth Building.

*The Board Members' Manual*—Charlotte K. Demorest—1952

Tells how to produce a manual and use it in board education. Such a manual can be made as brief or as inclusive as seems desirable. Each district board of directors may wish to consider this as a project.

*Measuring Your Public Relations*—Herman D. Stein—1952

Tells how to evaluate the effectiveness of your public relations program.

*The Public Relations Committee*—David M. Church—1949

Delves into the need for a public relations committee, the attitudes of the association toward the work of the public relations committee, the functions of such a committee and how to implement its functions. Should be studied by every public relations committee member.

*Public Relations Programs*—Sallie E. Bright—1950

Discusses how to establish a program, the inclusiveness of the program, who is responsible for a program, cost (what you make it!) and importance of a sound continuous program.

*Radio—How, When, and Why to Use It*—Beatrice K. Tolleris—1946

Study this when you have something to get across to the public.

*Working With Newspapers*—Gertrude W. Simpson—1945

Takes a "look at yourself" in making newspaper contacts. Helps you to recognize news, how to write it for the paper, and how to measure the results. Every district publicity committee should have one for study.

## BOOK REVIEWS

*Planning the Older Years.* Edited by Wilma Donahue and Clark Tibbitts. University of Michigan Press, 1950.

Problems of older people are brought to attention in this symposium of doctors, consultants, professors and other authorities. It emphasizes the emotional, social, and financial needs of older people and is written in a clear, realistic manner that would be of interest to anyone concerned about the old-age problem.

MARY JUNE MASON, R.N.

*Growing Older in the Years.* Edited by Wilma Donahue and Clark Tibbitts. University of Michigan Press, 1951.

Increased number and proportions of old people in the population has presented new social problems. National authorities have contributed information on several topics dealing with older people. Emotional needs of older people, psychiatric techniques in the treatment of older people, education of older people, community and industrial health of older people, and training for volunteers in the community service with older people are discussed. These problems are discussed in a clear, concise manner so that this book may be of interest to the layman as well as the professional worker.

MARY JUNE MASON, R.N.

## NEW BOOKS AVAILABLE IN THE MEDICAL LIBRARY

Bookmiller, Mae M. and Bowen, George L. *Textbook of Obstetrics and Obstetric Nursing.* W. B. Saunders Company, Philadelphia and London, 1954.

Sellew, Gladys and Pepper, Mary F. *Nursing of Children.* W. B. Saunders Company, Philadelphia and London, 7th edition, 1953.

Bower, Albert G. and Pilant, Edith B. *Communicable Diseases*—A textbook for nurses. W. B. Saunders Company, Philadelphia and London, 7th edition, 1953.

Stafford, Edward S. and Diller, Doris. *A Textbook of Surgery for Nurses.* W. B. Saunders Company, Philadelphia and London, 2nd edition, 1954.

Lyon, Robert A. and Wallinger, Elgie M. *Mitchell's Pediatrics and Pediatric Nursing.* W. B. Saunders Company, Philadelphia and London, 4th edition, 1954.

Bogert, L. Jean. *Fundamentals of Chemistry.* W. B. Saunders Company, Philadelphia and London, 7th edition, 1953.

O'Hara, Frank J. *Psychology and the Nurse.* W. B. Saunders Company, Philadelphia and London, 4th edition, 1954.

Goodnow, Minnie. *Nursing History.* W. B. Saunders Company, Philadelphia and London, 9th edition, 1953.

Pearce, Evelyn C. *Nurse and Patient—An Ethical Consideration of Human Relations.* J. B. Lippincott Company, Philadelphia, London and Montreal, 1954.

Brown, Martha Montgomery and Fowler, Grace R. *Psychodynamic Nursing.* W. B. Saunders Company, Philadelphia and London, 1954.

Price, Alice L. *The Art, Science, and Spirit of Nursing.* W. B. Saunders Company, Philadelphia and London, 1954.

Dooley, Marion S. and Rappaport, Josephine. *Pharmacology and Therapeutics in Nursing.* McGraw-Hill Book Company, Inc., New York, Toronto and London, 1953.

Langley, L. L. and Cheraskin, E. *The Physiology of Man.* McGraw-Hill Book Company, Inc., New York, Toronto and London, 1954.

# Amebiasis[1] a "Poorly Reported" Disease

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*Endamoeba histolytica* (*trophozoite*).

1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. *42*:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, California Med. *76*:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, Rev. Gastroenterol. *20*:667 (Sept.) 1953.

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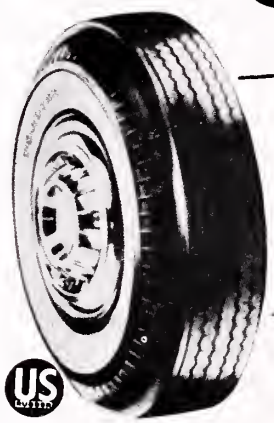
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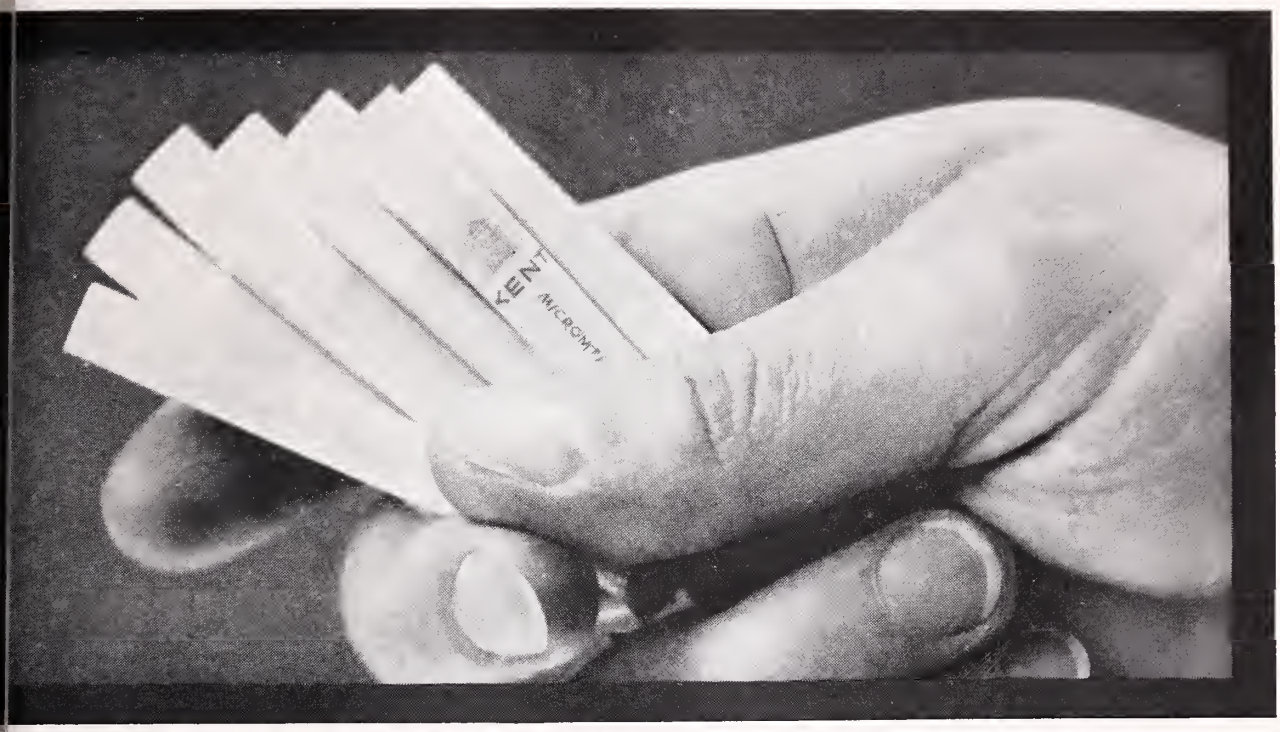
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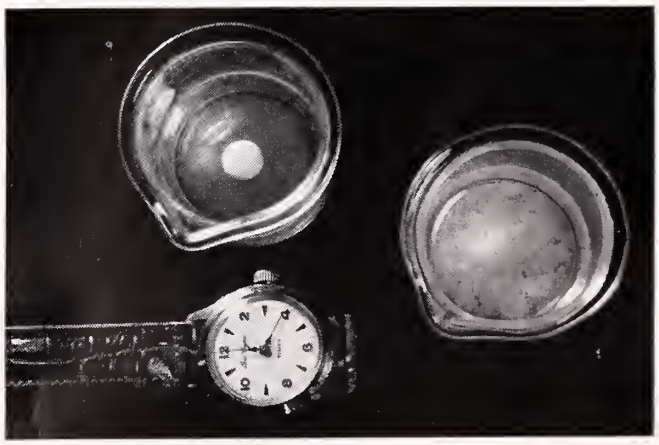
—Five minutes later, *Filmtab** coating has already ed to disintegrate. The tissue-thin film actually begins ssolve within 30 seconds after patient swallows tablet.



3:30—*Filmtab** is now completely dissolved. At this stage, ERYTHROCIN is ready to be absorbed, and ready to destroy sensitive cocci—even those resistant to other antibiotics.



5—Now the *Filmtab** tablet mushrooms out with all of drug available for absorption. Note that enteric-coated et is still intact. Tests show that the new Stearate form nitely protects ERYTHROCIN against gastric acids.



4:00—Because of *Filmtab** (marketed only by Abbott) the drug is released faster, absorbed sooner. In the body, effective ERYTHROCIN blood levels now appear *in less than 2 hours* (instead of 4-6 hours as before).

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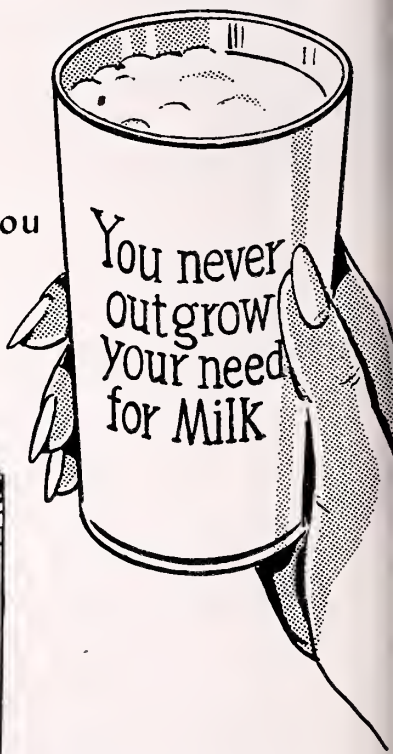
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**ACHROMYCIN** has definitely fewer side-reactions than certain other broad-spectrum antibiotics.

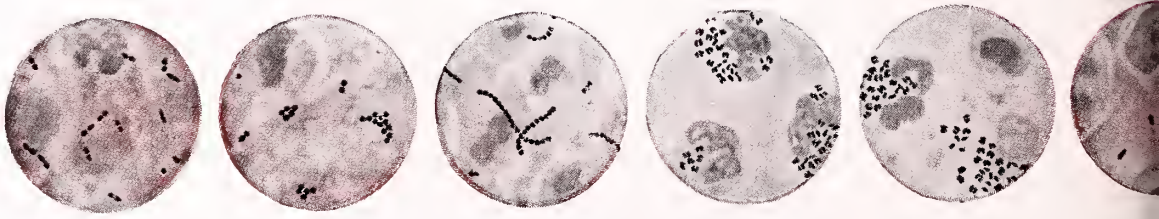
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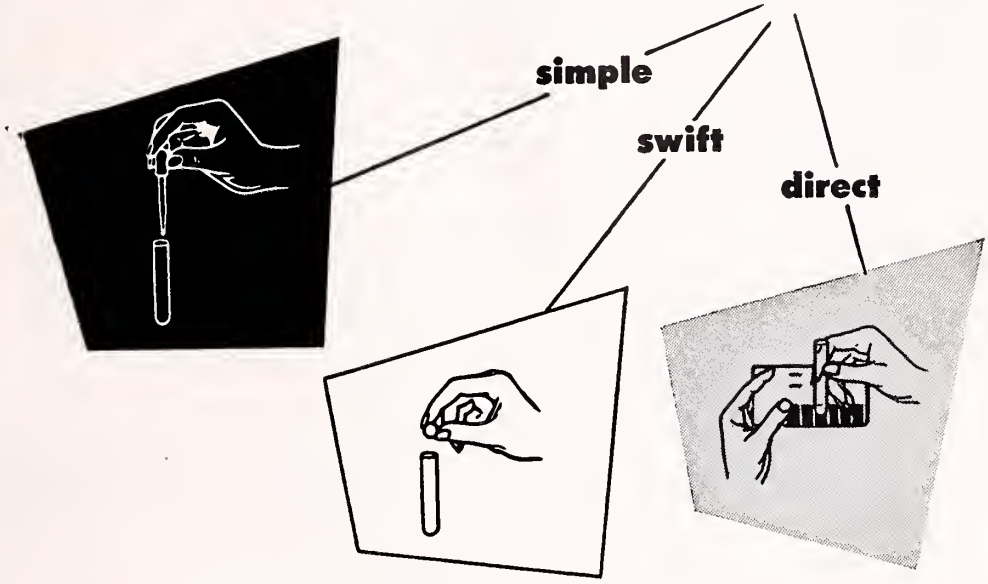
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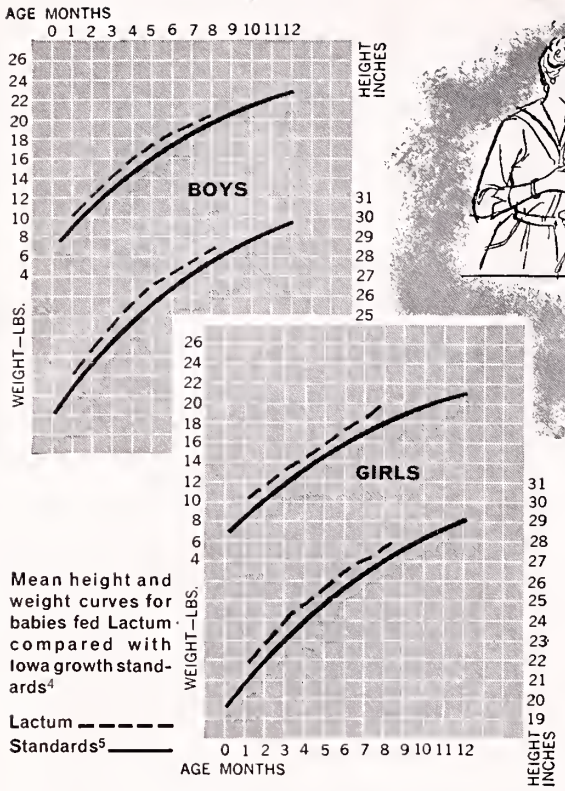
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Lactum feedings are easy to prepare. One part of Liquid Lactum to 1 part of water, or 1 level measure of Powdered Lactum to 2 ounces of water, makes a formula supplying 20 calories per fluid ounce.

(1) Jeans, P. C.: In A.M.A. Handbook of Nutrition, Ed. 2, Philadelphia, Blakiston, 1951, p. 275. (2) Albanese, A. A.: Pediat. 8: 455, 1951. (3) Holt, L. E., Jr., and McIntosh, R.: In Holt Pediatrics, Ed. 12, New York, Appleton-Century-Crofts, Inc., 1953, pp. 175-178. (4) Frost, I. H., and Jackson, R. L.: J. Pediat. 39: 585, 1951. (5) Jackson, R. L., and Kelly, H. G.: J. Pediat. 27: 215, 1945.

*Calculated on the basis of a daily allowance of 3.5 Gm. per Kg.*

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